Proceedings of the National Symposium on

March 12 - 15, 1989

Conference Centre, Victoria, B.C.

Sponsored by: The Provinces and Territories of Canada

Hosted by: Ministry of Health, Province of British Columbia and the Capital Regional District

These proceedings were prepared by Pat Wolczuk, Judith McDowell and Ken Ainslie through the auspices of the Community Health Services of the Capital Regional District, Victoria, B.C.

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Le Secrétariat des Conférences intergouvernementales canadiennes nous a avisé que le texte en français sera disponible en novembre 1989.

National Symposium on Health Promotion and Disease Prevention

Victoria, British Columbia.

Sponsored by:
The Provinces and Territories of Canada

Hosted by:
Ministry of Health, Province of British Columbia and The Capital Regional District

Attended by:
Invited delegates selected by their Province or Territory

90-03061/

BACKGROUND TO THE CONFERENCE

In 1977, the World Health Assembly, the central authority in the World Health Organization (WHO), resolved that "the main social target of WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." This resolution defined health as a resource for everyday living, not an end product or goal of living.

According to the International Conference on Primary Health Care held in Alma-Ata in the U.S.S.R. in 1978, the key to achieving this goal is primary health care.

At a meeting in Fez, Morocco in 1980, the WHO Regional Committee for Europe adopted a regional strategy for health for all by the year 2000 as the Member States' first common health policy. The committee endorsed specific targets describing the minimum progress that the European countries must make in improving health and problems related to it in 1984. Six main themes run throughout the targets.

- **Inequalities in health should be reduced.**
- **People should have a positive sense of health.The focus should be on health promotion and disease prevention.**
- **The people themselves will achieve health for all. Communities must participate in determining their health goals and strategies.**
- **Health authorities can deal with only part of the problems to be solved. Multisectoral cooperation is essential for the promotion of healthy public policy and reduction of risk.**
- **Services should be provided as close as possible to where people live and work. Services should be readily accessible and acceptable to all; they should be planned with full community participation.**
- **Some health problems transcend provincial and national borders. Pollution and trade in health-damaging products are obvious examples of problems whose solution requires international cooperation.**

In 1986, Health and Welfare Canada focussed attention on health promotion by developing a framework for health in it s document **Achieving Health for All. Health promotion is the "process of enabling people to increase control over and to improve their health."** In the past, health promotion has been associated with posters and pamphlets. However, **Achieving Health for All** clarifies that this as a simplistic view akin to associating medical care with white coats and stethoscopes. It states that in fact health promotion "represents a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health to create a healthier future."
Achieving Health for All identified three major health challenges.

Reducing inequities.
Increasing prevention.
Enhancing coping.

It also identified three mechanisms intrinsic to health promotion.

Self care.
Mutual aid.
Healthy Environments.

Three leading strategies for responding to our health challenges were proposed.

Fostering public participation.
Strengthening community health services.
Coordinating healthy public policy.

The document concludes that: "There is a certain timeless about health promotion. The signs are evident across the country. Regional boards of health, professional organizations, provincial and national councils and voluntary associations are all articulating policies that support the concept of health promotion. the most convincing evidence is the voice of public support. People everywhere are demonstrating a willingness to act on matters of health."

In November of 1986, the World Health Organization, Health and Welfare Canada and The Canadian Public Health Association hosted an international conference in Ottawa which adopted the **Ottawa Charter for Health Promotion.** The Charter identified five health promotion actions.

Build healthy public policy.
Create supportive environments.
Strengthen community actions.
Develop personal skills.
Reorient health services.

The conference participants pledged a commitment to health promotion as a national and international strategy for achieving health for all.

A second international conference on health promotion took place in Adelaide in the spring of 1988. Its theme was healthy public policy. This was defined as being "characterized by an explicit concern for health and equality in all areas of policy and an accountability for health impact." Conference delegates emphasized the importance of public accountability for health when policies are formulated, the need for new partners and collaborative measures to support health, and a commitment to reducing the inequalities in health which are rooted in the inequalities in society. A commitment to global public health - from peace and human rights to sustainable development - was considered an essential part of healthy public policy.

The National Symposium on Health Promotion in Victoria is sponsored by the provincial and territorial governments of Canada. It is intended to act as a catalyst for increased efforts in health promotion and disease prevention. The goal of the symposium is to achieve some consensus on our priorities for action.

WELCOME

It is a great pleasure for us to welcome you to Victoria, British Columbia for the National Symposium on Health Promotion and Disease Prevention, jointly sponsored by the Provinces and Territories of Canada.

Such issues as population aging, new technology, and the changing patterns of disease and disability in our modern society pose a major challenge to our excellent health care system as we seek to further improve the quality of care and the health of Canadians in the years ahead.

There is a great deal of interest and enthusiasm for a renewed focus on promotion and prevention as a strategic means of achieving our objectives for a healthier tomorrow. It is our hope that the meeting in Victoria will promote a stimulus to further action in this regard, and lead to the development of additional coordinated initiatives across Canada.

Through a combination of challenging plenary addresses, reports and panel discussions, as well as concurrent program presentations and policy working groups, the Symposium will provide an excellent forum for your participation. We are confident it will succeed in spurring us all to greater action in prevention and promotion.

To your very good health, and that of all Canadians.

Hon. Peter Dueck
Minister of Health
Province of
British Columbia

Mayor Susan Brice
Chairman,
Capital Regional District

LOCAL ORGANIZING COMMITTEE

Alan Campbell, Acting Executive Director, Program Support Services, Community & Family Health, Ministry of Health

Brian Copley, Assistant Deputy Minister, Community & Family Health, Ministry of Health

Perry Kendall, Regional Health Officer, Community Health Services, Capital Regional District

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Marnie Dobell, Senior Policy Analyst, Policy Planning & Legislation, Ministry of Health

Arnold Skulmoski, Consultant, Services to the Elderly, Mental Health Services, Community & Family Health, Ministry of Health

Mr. Stan Dubas, Deputy Minister, Ministry of Health

Mr. Andrew Hume, Director, Information Services, Ministry of Health

Tim Johnstone, Deputy Regional Health Officer, Capital Regional District

Mr. Marc-Andre Ouellette, Protocol Officer, Ministry of Toruism and Provincial Secretary

Mr. Paul Sekhon, Program Analyst, Hospital Programs, Ministry oh Health

Ms. Nan Selkirk, Coordinator, Executive Services, Deputy Minister's Office, Ministry of Health

Ms. Sue Stovel, Consultant, Nutrition, Member - Minister's Advisory Committee on Wellness and Health Promotion

This report has been compiled by editing directly from the transcripts of the conference. The authors have made every attempt not to alter the the flavour of any report. Sincere apologies for any errors or omissions.

PURPOSE

Following their 29th Annual Conference in Saskatoon, the Premiers directed that this National Symposium be held: "to act as a catalyst for nation-wide planning on coordinated initiatives in Health Promotion and Disease Prevention to balance the attention now being directed toward treatment of disease."

The Symposium has therefore been planned as a forum in which delegates can share information, debate, and build consensus on the future of health promotion in Canada. In order to accomplish this, the agenda will focus attention on the challenges facing health promotion and actions needed to implement health promoting policies, plans and programs in the Provinces and Territories of Canada.

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SUNDAY

MARCH 12

Display Set-up

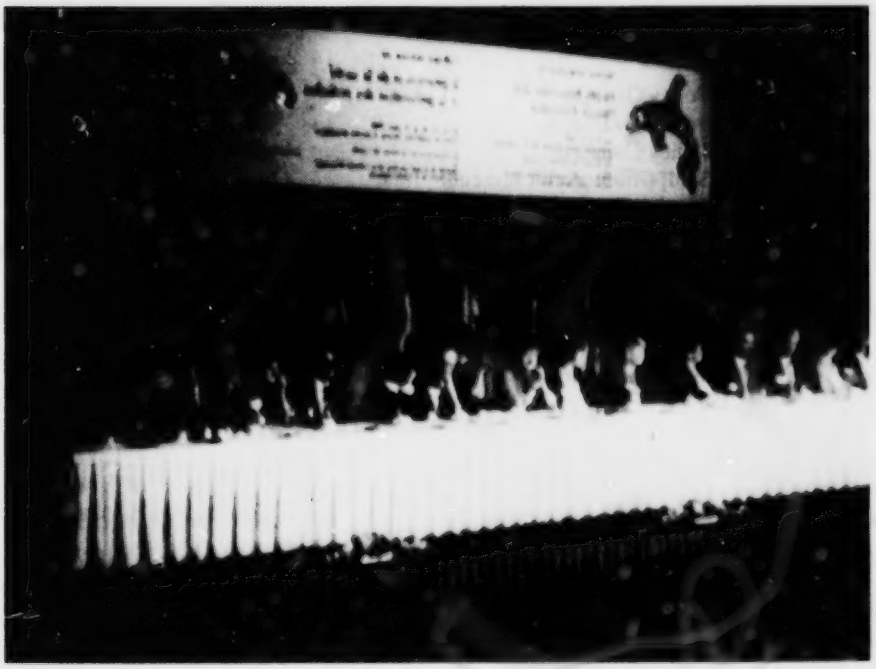
Registration

No Host Reception

Welcoming Dinner:
Honourable Peter Dueck
Minister of Health
Province of British Columbia

Her Worship Susan Brice
Chairman
Capital Regional District

Ilona Kickbusch, Ph.D.
Keynote Address
Back to the Future:
Moving Public Health into the '90's



MONDAY

MARCH 13

CHALLENGES

Registration

Milton Terris, M.D., M.P.H.
The Road Ahead for Health Promotion and Disease Prevention

Robert Evans, Ph.D.
Behavior and Biology:
A Wider Perspective on the Health of Canadians

Break

Provincial Reports:
Pat Wolczuk, Ph.D. British Columbia
Marc Gallop, M.Sc. Alberta
Urich Wendt, M.A. Manitoba
Robert MacMillan, M.D. Ontario
Marc Dionne, M.D., M.P.H. Quebec
Theresa Marie Underhill, M.Ed., M.H.S.A. Nova Scotia

Luncheon:

Honourable Elinor Caplan
Minister of Health - Ontario
Special Report

Maureen Law, M.D., M.Sc., D.P.H.
Health Promotion: A Dynamic for Change

Break

Concurrent Sessions: See page 121
Series 1: Community Health Promotion
Series 2: Heart Health
Series 3: New Structures for Health
Series 4: Community Health Promotion
Series 5: Problem Specific Programmes

Policy Groups meet

Welcoming Reception

TUESDAY

MARCH 14

ACTIONS

Registration

Sharon Macdonald, M.D.
Policy Groups' Report on Challenges

Trevor Hancock, M.B., M.H.Sc.
Where the Rubber Hits the Road:
From Health Promotion Rhetoric to Health Promotion Action

Break

Partners for Health in Communities
Chair: Gerald Dafoe, M.H.A. Ottawa, Ont.
Jean-Pierre Belanger Montreal, PQ
Madeleine Blanchet, M.D.Sillery, PQ
Michael Bopp, Ph.D.Pincher Creek, Alta.
Ken Fyke Victoria, BC
Dean Jock Murray, M.D. Halifax, NS
Shanti Radcliffe London, Ont.
Anne Usher Ottawa, Ont.

Luncheon:

Partners for Health in Government
Chair: Her Worship Susan Brice Victoria, BC
Marc Dionne, M.D., M.P.H. Quebec, PQ
Mavis Hurley, M.H.A. Fredericton, NB
Marilyn Knox Toronto, Ont.
Rheal Leblanc Edmonton, Alta.
Blenis Nicholson, M.A. Halifax, NS
Jonathon O'Riordan Victoria, BC

Break

Concurrent Sessions: See page 121
Series 1: Partners in Health
Series 2: Research and Training Issues
Series 3: Problem Specific Programmes
Series 4: Healthy Communities

Policy Groups meet

WEDNESDAY

MARCH 15

OPPORTUNITIES

Registration

Sharon Macdonald, M.D.
Policy Groups' Report on Actions

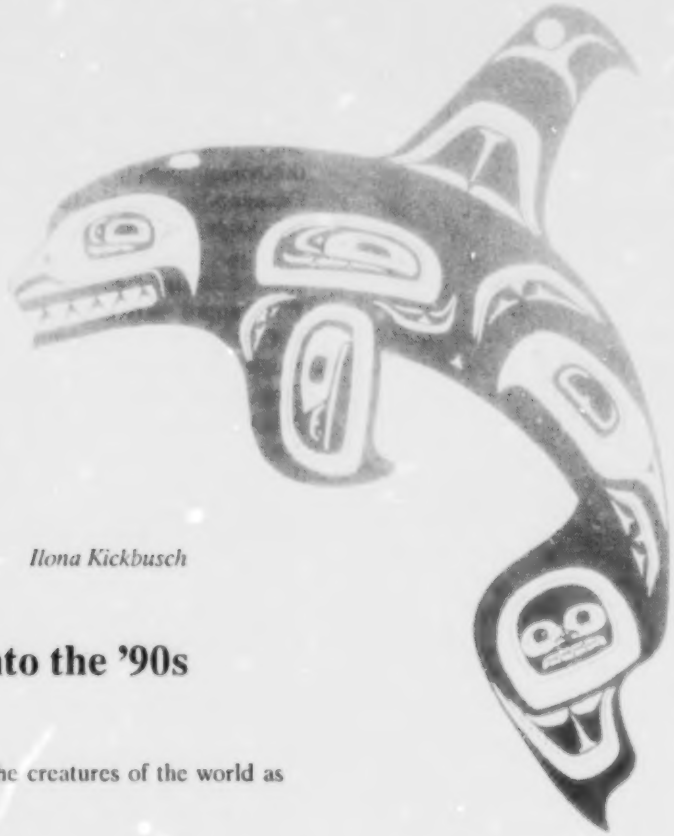
Policy Consensus

Break

Stan Dubas
Symposium Achievements

Honourable Peter Dueck
Concluding Address

BACK TO THE FUTURE



Ilona Kickbusch

Moving Public Health into the '90s

Some 2,500 years ago, Lao Tse described the creatures of the world as follows:

"Some go in front, some follow,
Some blow hot, when others are blowing cold.
Some are feeling vigorous, just when others are worn out.
Some are loading just when others are delivering."

Surely, this is the stage health promotion is in worldwide. Some are leaders and some are followers; some are moving ahead and some are waiting to see what happens.

Canada has consistently gone in front in the area of health promotion. It has helped shape health promotion history on a world scale.

Canada has consistently gone in front in the area of health promotion. It has helped shape health promotion history on a world scale, and one could even go so far as to say that the history of health promotion, as an identified area, began in your country in 1974 with the Lalonde report.

Another step in history was made here in Canada in 1978, when the world's first health promotion directorate was set up within the federal Department of National Health and Welfare. It has remained a unique type of directorate, with a very broad range of professional involvement, a very broad range of programs and a very special way of working in a

decentralized manor. In travelling around the world, I have not yet found anything like it.

So far, both directors have not been medical people but have come from the field of social policy and social welfare. This, too, is an innovation, and this commitment to a wider approach to health promotion has also made Canada a leader in the field. This approach was strongly supported on the NGO side by the Canadian Public Health Association.

These developments have helped make Canada a strong supporter for the WHO approach to health promotion and health for all. This was reflected in 1986 in the second seminal health promotion document from Canada, which was launched at the First International Conference on Health Promotion in Ottawa. *Achieving Health for All* was one of the first health policy documents worldwide with an explicit commitment to equity in access to health, to health promotion and to healthy public policy, all in one document.

The Seventies: A New Epidemiology

The 1974 Lalonde report influenced the formulation of health policies worldwide - much more than within Canada itself. The 70s, though, were also the heyday of the risk factor concept, the growth period of behavioral epidemiology and the time of the grand multi-million dollar lifestyle intervention projects.

The United States pioneered the development of what has been termed the second revolution in public health: that of non-communicable disease epidemiology. This revolution eventually stripped epidemiology and public health of their social concerns. Despite the statement made in *Healthy People,* the Surgeon General's report of 1979, this development proceeded to cut links between public health and epidemiology to such an extent that became necessary to state that "without public health, there is no epidemiology." I think that is historically shocking.

"Future historians of health promotion will probably divide the modern era into two periods: pre-Charter and post-Charter, referring to the first International Conference on Health Promotion in Ottawa, Ontario, Canada, in November, 1986, and the Ottawa Charter for Health Promotion."

The risk factor concept was rapidly accepted throughout the developed countries, and the large U.S. studies influenced health research budgets and institutional priorities worldwide. Behavioral epidemiologists claimed to be the modern successors of Villerme, Snow, Chadwick, Virchow and Winslow. Out of this developed the United States's approach to health promotion, which was built on a coalition between clinical medicine, behavioral epidemiology, functional sociology and the new profession of health education. Their magic "open sesame" was lifestyle, downplaying the initial broad-gauged concerns of the public health movement.

Meanwhile, in Europe in the early '70s, the North Karelia Project in Finland started its work; this was also the era of the West German blood pressure study and a number of smaller European projects that are also being monitored by WHO, through projects such as CINDI and MONICA.

The risk factor approach and the educational models applied in it which emphasize personal choice, lifestyle and individual behavior have been explored the world over, including the developing countries. Due to the public health and epidemiology training shortage in many European countries and in the developing world, the schools of public health in the United States have had a seminal influence in shaping the approaches to public health, health education and health promotion worldwide. We have therefore not only exported our health problems, but also some of our more questionable solutions to the developing countries.

The Eighties: A New Public Health

By the early 1980s, the premises on which the risk factor model based its work were beginning to be questioned, as were the validity and actual impact of some of its results. A recent article stated: "Future historians of health promotion will probably divide the modern era into two periods: pre-Charter and post-Charter, referring to the first International Conference on Health Promotion in Ottawa, Ontario, Canada, in November, 1986, and the Ottawa Charter for Health Promotion."

What had happened in a period of only five years? To put it in a nutshell, WHO, the world's leading public health organization had rediscovered public health. It had reinforced this move with the Health for All Strategy, the 1984 Primary Health Declaration of Alma Ata, with a special focus in health promotion

This development was part of a larger health policy change that began in 1981 in the WHO Regional Office for Europe which produced its regional strategy establishing 38 health targets for Health for All. Out of the six priorities that were named in the document, health promotion was second, after equity and health.

Health Promotion thus became part of the work of the office of Dr. Mahler, the then Director General of WHO. Dr Mahler instigated a world wide consultation on health promotion. The Ottawa Conference and the Charter were results of that consultation. In preparing for the Ottawa conference, it became evident to us that we were not just engaged in a new type of health education or a slightly different approach to health and health care, nor were we establishing a new discipline called "health promotion."

We realized that we were beginning to write the public health agenda of the '90s and beyond. We received confirmation of this at the '86 conference, which produced the Charter and subtitled it "the move towards a new public health."

We were beginning to write the public health agenda of the '90s and beyond.

Why public health? By choosing "new public health," we wanted to link ourselves firmly to the broad beginnings of public health and thereby establish a sense of integration and continuity.

The need for continuity was reinforced by the constant debates we had been confronted with about the difference between health promotion, prevention, health education, primary health care and health for all, debates that were usually motivated by battles over professional turf.

"New public health" was also a signal that public health was part of a new context that would eventually mean working along the lines of a new paradigm. The term "old," therefore, is not meant to be derogatory, nor does the word "new" indicate that we have found all the answers. As Milton Terris has said: "Conventional wisdom holds that the public health movement began with a concern for the prevention of the infectious diseases and has only moved into the area of non-infectious diseases in the past few decades. This simple formulation is contrary to historical fact."

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The Dismantling of Public Health

Historically, public health has moved from the broad idea of sanitation to medicalization, which was based on the cause-and-effect model of germ theory, and from there to a focus on behavioral epidemiology. In the course of this process, health came to be interpreted as the control of disease rather than as a social phenomenon. It was linked to a system of cure and care and simplistic cause and effect measures rather than to a broadly based promotion of health.

Although many of the diseases to be tackled today, such as heart disease and cancer, clearly represent mass risks, which are heavily related to living conditions and social inequities, they were being tackled with individual approaches.

The link to cure and care had another devastating effect on public health. The financial support for health promotion and prevention was linked to expenditures for cure and care. More and more, these are seen as expenditures that modern welfare states cannot no longer afford. How, if we can't afford our present health systems (which aren't health systems but curative systems), how will we ever find money for an extra undertaking?

Focussing attention on health promotion is hampered by the general invisibility of the new risks, be they social, like poverty and unemployment; or medical, like heart disease; or environmental, like pollution-related disorders. They are silent. No dole queues, no stench in the streets, no declared diseases of poverty. They are cumulative. They present no clear causality and no simple solution. Most are linked to key social and environmental policy issues of the present and the future that many political decision makers would like to avoid.

It seems at first glance that despite the various stages of its modernization, public health has not changed its basic paradigm. It deals with today's health problems with the theories, approaches and often the morality of the

19th century. Public health has so far not acknowledged the changes in the overall risk patterns of our societies, and it is still dominated by belief in medicine, professionalism and individualization, by the notions of the deserving and the undeserving poor, and by a causation principle that builds on individual responsibility and believes that man dominates nature - and I consciously say "man."

Part of this history includes the different political approaches to public health. This aspect of public health ranged from Chadwick's utilitarianism to Alexandra Kollontai's radical attempt to create a community-based public health. It included Hitler's cult of health. (The German public health service was reorganized under the Third Reich and still works according to the organizational principles put forward then.) It includes welfare state approaches as in the Red Vienna of the early '30s, and the establishment of the European welfare states.

The political history of public health still remains to be written in order to give us a picture of where we come from when we go back to the future. However, the key thing to be aware of in this connection is the fact that the foundation of public health action, and therefore of the new public health, is laid in the political arena of social reform and social control.

The Nineties: Ecological Public Health

What then would be the first steps towards a third public health revolution? What are the indications that we are ready for such a move or that perhaps our only chance lies in such a move?

What we are witnessing at present is the cumulative effect of a set of processes of change and development that have been occurring over the last 10 to 20 years in our societies as a whole, not just in health. This is what I call the context of the new public health. Changes in the health arena are now coming to fruition; and, in the issue of health, the societal problems of today and tomorrow have found a focus.

Health is increasingly being seen as a common social good that needs to be preserved and that calls for social investment. Above all, we are beginning to realize that health is indivisible. It is a global good, and to speak in the new ecological language, it is a "commons" that can no longer be safeguarded by national policies and boundaries.

Health is increasingly being seen as a common social good that needs to be preserved and that calls for social investment. Above all, we are beginning to realize that health is indivisible. It is a global good, and to speak in the new ecological language, it is a "commons" that can no longer be safeguarded by national policies and boundaries.

The two key international policy declarations that mark this fact are the WHO "Health For All" strategy of 1978, and the 1987 report of the World Commission on Environment and Development entitled *Our Common Future.*

Again, Canada was there to help us clear our minds about going beyond health care to the new public health. The 1984 conference in Toronto was one of the first in the world to establish a link between the new ecological

concerns and public health and health promotion. It called for a new type of public health policy: what was to become "healthy public policy."

The major difference between the old and the new public health lies in the new global ecological risks we are faced with worldwide and the challenge of developing a global public health. There is no precedent, no analogue, to problems such as human-caused threats of ozone layer destruction, depletion of natural resources, chemical compounds, nuclear disaster, or genetics.

The major difference between the old and the new public health lies in the new global ecological risks we are faced with worldwide and the challenge of developing a global public health. There is no precedent, no analogue, to problems such as human caused threats of ozone layer destruction, depletion of natural resources, chemical compounds, nuclear disaster, or genetics.

What was once interpreted as costs of production looms large, cumulatively and silently. As Gary Brewer, a U.S. policy analyst said: "There is no 'away' in which to throw such things anymore. And there are no slave ships in which we can put people and send them somewhere."

An ecological paradigm of public health is not only a plea to pay more attention to new environmental problems and to create strong administrative structures in doing so, although that would be a reasonable first step. Ultimately, we must reconsider health in terms of an ecosystems approach.

Health, then, emerges as "a pattern that connects" these diverse cumulative effects of the natural, the man-made and the social environment. In such an approach, man is not seen as external to nature, but humankind is "an integral and especially precocious component of the environment," contributing: skill, wealth, power, wellbeing, affection, deference, and rectitude.

Today, we are confronted with a set of public health problems that are global in scope, finite in their consequences, still not fully understood in terms of their cumulative causation, usually invisible and not so far a political priority.

A new public health theory is, therefore, not only challenged by the need to reinstate the social and environmental concerns of the old broad-gauged public health, it is also challenged to respond to changes in society that according to some analysts, are as fundamental as the move into industrial society in the 19th century.

The old public health movement was part of a major reshaping of the world. It was a tool used by different political ideologies to realize their vision of society: a major social, economic and political investment based on political choice. Just try and envisage what it cost, financially and politically, to introduce a sewage system into a 19th-century city. Then compare what you are trying to do now to shift resources from cure to prevention. By looking back in this way, we can help prepare ourselves for the future.

Action Steps: International Action

If these are the issues of the future, what is WHO doing to move ahead? What are other countries doing, and what can Canada do to remain the one that goes in front?

1. The executive board of WHO has decided to put to the World Health Assembly this year a proposal for shifting WHO priorities worldwide, to link with the Bruntland Report and the key notion of sustainable development. As Dr. Bruntland said in her speech to WHO's assembly last year in answer to criticisms why the report had not spoken more about health, the whole report is about health. The WHO Health Promotion Project has consistently been going in this direction. The consensus document accepted in Ottawa in 1986 chose a supportive environment as one of the five key areas for health and identified it as being linked to an ecological system.

"Our societies are complex and interrelated. Health cannot be separateed from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility."

A new public health theory is, therefore, not only challenged by the need to reinstate the social and environmental concerns of the old broad-gauged public health, it is also challenged to respond to changes in society that according to some analysts, are as fundamental as the move into industrial society in the 19th century.

2. The WHO concept of health promotion is becoming more consistently accepted world-wide. We know of 30 translations of the Charter so far; millions of copies of the Charter that are circulating, and programs and policies are being built on it all over the world. We are just now in the process of planning a worldwide study of its impact. The Adelaide conference on healthy public policy reinforced supportive environments as one of the four key areas for policy action.

"The most fundamental challenge for individual nations and international agencies in achieving Healthy Public Policy is to encourage collaboration (or developing partnerships) in peace, human rights and social justice, ecology, and sustainable development around the globe. At an international level, the World Health Organization should play a major role in achieving acceptance of such principles and should support the concept of sustainable development."

3. In the course of preparing for the third international conference on health promotion in Sundsvall, Sweden in 1991, we are tackling this issue head-on. This conference has the support of the five Nordic countries, the Nordic Aid agencies, the new division of health education and promotion at WHO Headquarters, the environmental health division at WHO

Headquarters and, we hope, the two host countries of the first two health promotion conferences, Canada and Australia.

4. The Australian Commission for the Future is hosting an Australian workshop on sustainable development and health, which will make proposals for the Sundsvall agenda to WHO and proposals to the Australian Commonwealth for their involvement. One of the four key areas of the Australian Commission for the Future's work will be "healthy futures." Canada will be hosting a similar event on sustainable development, with an international workshop in 1990. We have established contacts with environmentalists and experts. Two workshops on health promotion and developing countries are in preparation.

One of our key action areas is healthy cities. Here again, Canada has played a key role.

From Analysis to Action

1.The Sundsvall Conference wants to move from consensus, which we had in Ottawa, and analysis, which we had in Adelaide, to agendas for action on the two key issues of healthy public policy equity and accountability.

We are planning to develop briefing books outlining policy options for health based on sustainable development. Seven areas have been selected so far: agriculture, energy, environment, transport, education, housing and work.

On all these issues, we hope that three levels will go through the conference: agendas for cooperation (the briefing books), infrastructures for cooperation (models of good practice), and infrastructures for the new public health.

This is even more appropriate because the developing countries are faced with the old and the new public health problems at the same time, and Sundsvall will be the first of the health promotion conferences to have a majority of participation from the developing world.

There is a tendency within public health and health promotion to underestimate the time it takes for setting new agendas.

2. One of our key action areas is Healthy Cities. Here again, Canada has played a key role in developing and promoting the project. At present, we have 25 project cities (soon to become 32) and 12 national networks. In addition, about 300 cities worldwide have begun to work with the concept. At WHO Headquarters, urban development has been named as one of the areas of concentration for the organization to focus on worldwide.

The process of defining a problem and getting a social consensus on it is not easy, and it moves through several changes of rhetoric.

Canada has also helped us in indentifying an appropriate organizational structure at the national level through the Canadian Institute of Planners and the Federation of Canadian Municipalities. We are trying to motivate the European national networks to work with groups outside the health sector, and at the provincial level, to follow the example of Quebec.

3. The Healthy Public Policy project I'd like to mention is an attempt to analyze the processes of formulating and implementating healthy public policies.

Using the results of the analytic literature review prepared for the Canadian government at the end of 1988, we are inviting representatives to comment on new organizational forms and supports for health promotion, and we will develop an options handbook for organizations on "Infrastructures for Health Promotion."

Health Promotion as a Process

What we wish to focus on is political processes that lead to health promotion development. Before we discuss the three common elements and action proposals for such a process, let us first stress some general developmental notions.

There is a tendency within public health and health promotion to underestimate the time it takes for setting new agendas.

It took 50 years from the first proposals for wide-range sanitary measures to their general introduction by John Simon in the United Kingdom, for example. It took about 30 years from the discovery of the links between smoking and cancer to create a majority consensus on a smoke-free society.

The process of defining a problem and getting a social consensus on it is not easy, and it moves through several changes of rhetoric. But let's be honest. Who would have expected or imagined only five years ago the kind of public health issues we are now discussing worldwide? We are also discussing our own underestimation of the amount of change we have already brought about and what the public health movement often lacks - concrete proposals for action which we can proactively pull out of the drawer when the time and the opportunity arise.

Three elements are needed in order to develop strategies for implementing healthy public policy and for making health, health promotion, prevention, and protection a priority in political decision making. These are: an informed citizenry; a mobilized advocacy lobby; and contact points within the system.

Politics, ministers and key societal issues change all the time. Gaps that need to be filled with action arise continuously. Here again, we should not restrict our attention to health issues only, because public health needs to develop a better awareness of the general context and to hook onto other social issues.

The two key issues discussed at present in most industrial societies are being set by the electorate. Politicians from all parties are reacting to these issues, and even an iron lady has become a green lady: these issues are environment and aging.

It is essential that the general public begin to understand the health debate as reaching beyond health care.

Both have tremendous potential for the new public health debate. In Western Australia, a senior citizens' party won ten percent of the vote in a

recent state election. Were the public health people there to discuss their health strategy?

We need to discuss health, not in terms of the deficit model which classifies all moneys put into health as expenditure, but in terms of health as a commons, a social resource for a sustainable society.

In Canada nine out of ten citizens want more money spent on the environment. Where will it come from? From already existing programs; from taxes on tobacco and alcohol; from emission taxes? Some creativity is needed and the public health people should be providing it.

The Ottawa Charter outlined three new public health skills: to enable; to advocate; and to mediate. It did not advocate creating a new public health empire. The key challenge, then, is how to get health as an ecological and social category on the political agenda of the '90s.

Three Key Strategic Elements

Let me close by focusing on three elements needed in order to develop strategies for implementing healthy public policy and for making health, health promotion, prevention, and protection a priority in political decision making. These are: an informed citizenry; a mobilized advocacy lobby; and contact points within the system.

All three are interdependent because policy-making is an interactive process, shaped by and shaping society. And our experiences in Health For All and in the European Healthy Cities Project are showing how unpredictable and dynamic this process is.

1. An informed citizenry: redefining the agenda. It is essential that the general public begin to understand the health debate as reaching beyond health care. We here seem to have a relative consensus; out there, when we speak of health, people think health care and hospitals. That kind of change will be made by a public debate on health, and the media will play a key role in this.

Public health advocacy always works in at least three directions - towards the general public, towards decision makers, and, horizontally, to create new alliances.

We need to discuss health, not in terms of the deficit model which classifies all moneys put into health as expenditure, but in terms of health as a commons, a social resource for a sustainable society. The discussion, therefore, must move from the subject of expenditure to the subject of social investment, not only in terms of money but also in terms of social commitment and individual responsibility. It is not an issue of the state only.

A key issue has to do with the public's access to information about health and the introduction of some form of accountability on health matters. This applies at all levels, both for business and for public administration. Healthy Cities, for example, asks for an all-party consensus in city council on the project. Another example is the way you have tried in a broad way (though it is still perhaps, too professionally focussed) to discuss the Epp strategy all through Canada.

2. A mobilized advocacy lobby: moving the agenda to strategy. Two strategies are of importance here: on the one hand, to create a stable and strong new public health lobby or a public health coalition. This would involve a concerted move to bring together the many single issue initiatives that exist in the health field and link them to broader lobbies in the environmental and ecological arena. That will be one of our key attempts for Sundsvall.

On the other hand, we must not lose sight of the ad hoc coalitions on specific issues. For example, it hit the headlines of the Australian newspapers when 100 Tasmanian medical doctors spoke up against a planned pulp mill and the health effects that such a pulp mill could have. If the health professions are willing to play an advocacy role, they will tend to get high media coverage.

The public health lobbies and coalitions need to be involved in constant briefings of potential political allies in all parties; and they need to have documents that can establish alliances on wider health issues in order to proactively set a new health agenda and move out of the reactive mode.

Since public health advocacy always works in at least three directions - towards the general public, towards decision makers, and, horizontally, to create new alliances - new arenas and new techniques have to be explored. The constituencies for health have to be redefined to extend beyond health care. Business has to be encouraged to see health as part of its social agenda. For example, in Germany and in many countries of Europe, health is becoming an issue in the location of industries, and cities are interested in presenting a good health record in order to get new industries to locate there.

The CPHA and the healthy communities project could play a major role in developing such a coalition, particularly one that includes those interested in ecology. A challenge to the lobbies is that they not only need to investigate new problems and make them public; they also need to rethink the systems and infrastructures based on the deficit model.

Let us not forget when we are discussing advocacy that advocacy issues and trends shift as well. In the '60s and '70s, advocacy was usually in the direction of more government intervention on social issues. In the '80s, most advocacy was towards less government involvement and less government expenditure. And we are not quite sure yet where we are moving in the '90s. But one thing we are definitely seeing is that people are demanding more government action on the environment.

3. Contact points in the system: supplying agendas and solutions. The public health lobbies and coalitions need to be involved in constant briefings of potential political allies in all parties; and they need to have documents that can establish alliances on wider health issues in order to proactively set a new health agenda and move out of the reactive mode.

More consciously, we need to analyze the political struggles over health, particularly the non-decisions, and relate the new environmental concerns to the health debate and the health budget. Health proponents will need

to acquire new expertise and new skills because most non-decisions take place through the budgetary process.

Thirteen starting points for action could be:

- First, lobby prominent people from all political walks of life to join the health coalition.

- Second, strengthen the health promotion infrastructures at federal, provincial and local levels. A good example for such a new health promotion infrastructure is in Wales, in the new Welsh Health Authority. In Canada, you also have quite a good infrastructure already.

- Third, create intersectoral committees for health, if possible, with a highly prestigious chair from outside the health field. For example, the Hungarian health promotion committee is chaired by a minister of state, who stands right next to the prime minister and has to account to the prime minister's office.

- Fourth, introduce direct reporting mechanisms to key decision makers and cabinet.

- Five, link these two measures to public accountability, particularly yearly health reports and health impact statements that can be understood not only by the public but by politicians as well.

- Six, create a system of financial incentives from the federal government to reinforce health promotion and new public health development at the provincial level and give priority to social investment in health. Examples exist in the organization of financing for health insurance, hospital insurance or facilities construction.

We need to be clear that if we want to tackle the new public health, we need new systems and infrastructures to promote, protect and maintain health, and that we are facing a challenge as big as in the 19th century when structures for the old public health were put in place.

- Seven, develop foci for discussions, such as a health plan, the process towards which can help redefine the agenda.

- Eight, set budgetary targets and goals. I would propose that by 1995, 25 percent of the health budget should be devoted to health. A similar figure is suggested in the book "Second Opinion".

- Nine, create visible centers for health promotion training and research at universities and colleges and develop seminars along the lines of the summer school in Alberta, for example. Such activities are starting up all over Europe.

- Ten, develop new partnerships for projects for health which involve matched funding between federal, provincial, non-governmental and private enterprise. Interesting examples exist, for example, in the Washington Business Group for Health, Business in the Community in Europe, and similar ones.

- Eleven, create health promotion foundations linked to tax income from harmful products and/or from polluting industries. For example, the new Health Promotion Foundation in Victoria, Australia, which is linked to tobacco tax has an annual income of 27 million to spend for health promotion.

- Twelve, strengthen community involvement in policy issues through the community projects already mentioned, particularly Healthy Cities.

- Thirteen, give grants to develop methodologies such as health impact statements, briefing books and public policy approaches.

We need to be clear that if we want to tackle the new public health, we need new systems and infrastructures to promote, protect and maintain health, and that we are facing a challenge as big as in the 19th century when structures for the old public health were put in place.

Again, just imagine what it cost to create the public health systems in Liverpool or the political costs of the introduction of social insurance under Bismark.

New Directions for Health Policy

Canada has gone in front in a systematic, committed way, and it has followed through its health promotion commitment in its work with the World Health Organization. While the three major challenges in the Epp document remain and need to be met with clear action proposals, visible financial commitment remains to be added, as well as the ecological challenge. Leadership is essential in this case, and it will not necessarily come out of the health field.

Milton Roemer has recently reinforced the idea that we need new public health leadership, a new profession of generalists who can appreciate the enormous variety of problems affecting the health of populations and the very wide range of strategies necessary to promote health and prevent disease or facilitate treatment when prevention has failed. He goes as far as to ask for a new doctor of public health with a status parallel to that of a medical doctor.

We have long passed the time when we lacked proof that health promotion is successful or that it pays off.

The greatest payoff is achieved if you move out of the health sector, get high societal involvement, a high media debate, link to political agendas, link to cultural identity, and involve the business world and the NGOs.

Accountability and the burden of proof now lie with the medical system to show in detail the payoff that has been received from swallowing 99 percent of the health budget.

It is here that the strength of health promotion and the new public health lies. Green and Raeburn have drawn attention to the fact that health promotion is one of the first and one of the few (along with public health) truly interdisciplinary health-related enterprises that seem genuinely emancipated from medicine.

Herein lies the great historical opportunity and challenge. Maybe health promotion can break the deadlock of the health policy debate that is basically about medical care and provider dominance. It must break the deadlock by redefining the issue of health expenditure. Only in this way could health promotion be attractive to politicians as a social and ecological investment in the future.

We have long passed the time when we lacked proof that health promotion is successful or that it pays off. This has been shown historically through the old public health and its long-term payoffs; it has been shown through general changes in our health cultures, our attitudes to drinking, smoking and the food we eat, even though these are still mainly middle-class concerns. But that's how the hygiene movement started in the 19th and 20th century, too.

It has been shown through long-term intervention projects, and even projects such as Heartbeat Wales that have only been running for a few years can document astounding success. The greatest payoff is achieved if you move out of the health sector, get high societal involvement, a high media debate, link to political agendas, link to cultural identity, and involve the business world and the NGOs.

Accountability and the burden of proof now lie with the medical system to show in detail the payoff that has been received from swallowing 99 percent of the health budget.

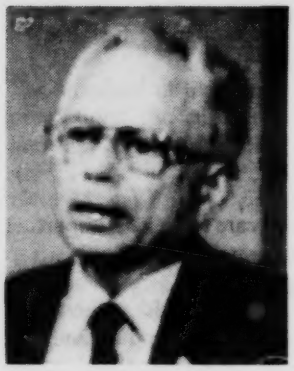
Health is not something that can be defined scientifically and normalized. The definition of what is health is always social and cultural not medical. Health links concerns for the environment and people. The new public health goes one step further: it is becoming intrinsically linked to social justice. Citizens are beginning to claim a right to health not just a right to access medical services. Public participation is a necessity.

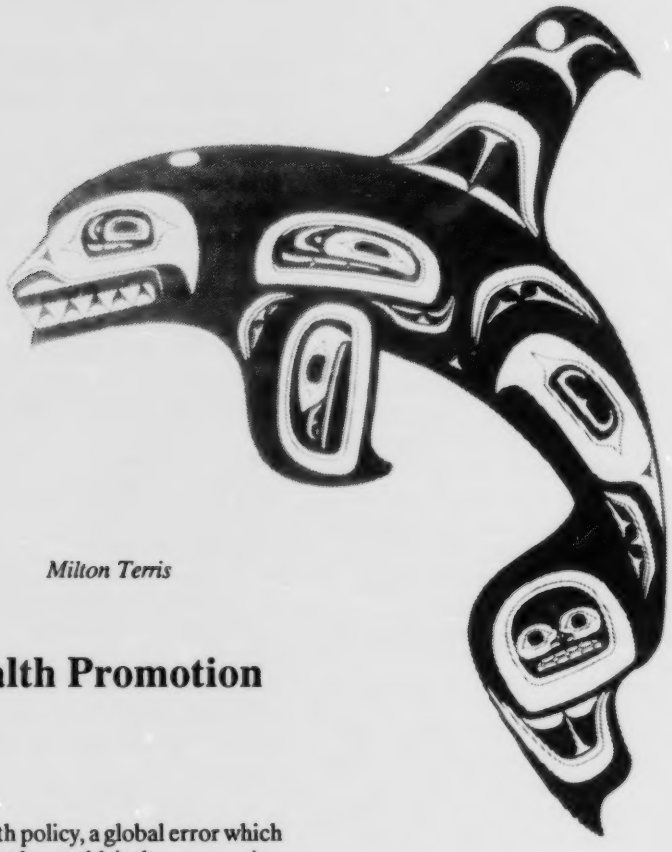
This societal opening of the debate on health has major consequences for the public and for professionals. "Participation" does not mean "meddling" in issues that supposedly only professionals can decide on our behalf, like what birth is best; it means deciding, at the community level, what prevention and health promotion measures are to be undertaken. "Public" means more than public administration of health; it refers to a societal accountability for health decisions.

As the Bruntland Report stated: "Most of today's decision makers will be dead before the planet suffers the full consequences of acid rain, global warming, ozone depletion, widespread desertification, and species loss. Most of today's young voters will be alive."

CHALLENGES

THE ROAD AHEAD





Milton Terris

The Road Ahead for Health Promotion and Disease Prevention

The most serious defect of current public health policy, a global error which has affected Canada and every other country in the world, is the assumption that creating a national medical care system is equivalent to establishing a national health program. Experience with the British and Canadian medical care systems has exposed the fallacy. Equity in access to medical care has clearly failed to assure equity in health.

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In England and Wales, the inequality and mortality of social classes has actually widened since the establishment of the National Health Service, nor has the Canadian medical care system achieved equity in health. Russell Wilkins and Owen Adams have calculated disability-free life expectancy for Canada in the late 1970s by income level. They found a step-wise progression by income level from the lowest to the highest fifth of the population.

In the late 1970s, in Canada, the difference in life expectancy between people in the lowest and highest income levels was four-and-a-half years. For disability-free life expectancy, the difference was 11 years. Think of it: 11 years difference.

Poor people in Canada have, on the average, only 55 years of healthy life - that is, life free from disability - as compared with 66 years of healthy life for rich Canadians.

It is essential that governments understand that a truly effective national health program must take account of all the determinants of health. Those determinants include three elements.

- A healthful standard of living.
- Prevention.
- Medical care.

Governments must also understand that medical care is the least important of these basic elements of a national health program.

An effective national health program is inconceivable without the achievement of a healthful standard of living for the entire population.

An effective national health program is inconceivable without the achievement of a healthful standard of living for the entire population. The improvement of physical and mental health cannot be realized unless fundamental human needs are met.

A healthful standard of living requires a sharp reversal of the world's perverted priorities, turning away from the astronomical escalation of military expenditures toward realization of the following objectives.

- Full employment.
- Adequate family income.
- Better working conditions.
- Decent and affordable housing including the elimination of homelessness and the blight of urban and rural slums.
- Good nutrition.
- Greater financial support to public education and the elimination of financial barriers to higher education.
- Improved cultural and recreational opportunities.
- Extension of participatory democracy so that ordinary citizens may directly influence the policies that govern their lives in the workplace, in the home and in the community.
- Affirmative action in all areas of national life to end discrimination against minority groups based on gender, age,

race, national background, social classes, religious belief, or sexual orientation.

- Freedom from fear of violence and from the threat of war, whether nuclear, chemical, bacteriological or conventional.

The diversion of national resources to military purposes makes it impossible to achieve a healthy economy and a healthful standard of living for people of all nations.

The standard of living represents the true content of the term "health promotion," the current popularity of which is matched only by the prevalence of confusion about its meaning. This confusion, I regret to say, started with the Lalonde Report and was then greatly magnified by the United States Public Health Service.

The standard of living represents the true content of the term "health promotion," the current popularity of which is matched only by the prevalence of confusion about its meaning.

What is health promotion? In 1974, the Lalonde Report proposed five health strategies, listing the first as: "A health promotion strategy aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health."

This error, the reduction of health promotion to health education and community organization, was reinforced by *Healthy People,* the Surgeon General's report on health promotion and disease prevention published by the U.S. Public Health Service in 1979. Their definition was: "Health promotion begins with people who are basically healthy and seeks the development of community and individual measures which can help them to develop lifestyles that can maintain and enhance the state of well-being."

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It is clear that the authors of *Healthy People* have defined health promotion to mean lifestyle modification for disease prevention. They proceed immediately to cite the Stanford Heart Disease Program and the Multiple Risk Factor Intervention Trial (MRFIT) as notable examples of: "... recent efforts to organize community resources for health promotion." And although Chapter 10 of the report is entitled "Health Promotion," it deals primarily with disease prevention.

What are the consequences of this definition? One is lack of credibility. When health professionals describe programs to lower serum cholesterol or reduce smoking as health promotion instead of disease prevention activities, they earn a reputation, eminently deserved, for vague concepts and muddled thinking. More significant, however, are the policy consequences. The main result of the semantic confusion is the submergence and neglect of real health promotion.

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The concept of health promotion refers primarily to the development of healthful living standards. These have a profound effect on all determinants of health. They have a profound effect on positive health,

which is not only a subjective state of well-being - including such elements as vitality, freedom from excess fatigue and freedom from environmental discomforts, such as excessive heat, cold, smog and noise - but also has a functional component: namely, the ability of the individual to participate effectively in society - at work, at home and in the community.

The standard of living also plays a major role in the prevention of disease and injury. Infant diarrhea, for example, the single most important cause of death in the world today, is caused only secondarily by salmonellae, shigellae and other micro organisms. It is caused primarily by underdevelopment, poverty, lack of basic sanitation facilities, undernutrition, illiteracy and ignorance of personal hygiene. The state of nutrition is a major factor affecting resistance to many diseases.

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Poor working conditions and hazardous environments are the cause of much preventable disease and injury. Dead-end jobs, inadequate incomes, poor housing, discrimination and lack of educational, cultural and recreational opportunities combine to produce low self-esteem, mental dysfunction, alcoholism, drug addiction, suicide, homicide, wife and child abuse, and other violence directed against self, family and community.

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Access to medical care is markedly affected by factors other than financial barriers. Educational levels, transportation problems and overcrowded, inadequate clinical facilities are particularly important in preventing optimal utilization of available resources.

Finally, rehabilitation cannot stop with physical measures. It must include social and vocational rehabilitation as well. Societal facilities - buildings, sidewalks, buses, cars, parking lots - must incorporate provisions to meet the needs of handicapped persons. Jobs must be available for them - a difficult thing to accomplish when a significant portion of the able-bodied work force is unemployed.

Canada has played a very important role in fostering greater understanding of the role of living standards in all aspects of health - enhancing well-being and functional capacity, preventing disease and injury, treating illness and rehabilitating the disabled.

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It was no accident that Ottawa became the site of the first International Conference on Health Promotion in November, 1986. The Canadian Minister of National Health and Welfare had previously emphasized "the means essential for the preservation of health: food, shelter, transportation, recreation, a healthy workplace" and urged intersectoral coordination in these areas. The Ottawa charter for health promotion puts the issue squarely, stating: "The fundamental conditions and resources for

health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites." The charter goes on to say: "The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned, by governments, by non-governmental and voluntary organizations, by local authorities, by industry and the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health."

"The prerequisites and prospects for health cannot be ensured by the health sector alone."

In any period, the public health agenda is the result of two basic considerations: one, the nature of the hazards to health; and two, our ability to counteract those hazards. During the 1920s, '30s and '40s, it became increasingly apparent that with the conquest of many of the major infectious diseases, the main causes of death and disability were the noninfectious diseases, but we were powerless to combat them. Their epidemiology was unknown and we clothed our ignorance with polysyllabic terms such as degenerative, idiopathic, essential and psychosomatic.

Unable to prevent the occurrence of these diseases, we retreated to a second line of defense, namely, early detection and treatment, so-called "secondary prevention." But secondary prevention has, with few exceptions, proved disappointing. It cannot compare in effectiveness with measures for primary prevention.

A periodic physical examination at the cancer detection center, multiphasic screening and a host of variations on these themes have incurred enormous expenditures for relatively modest benefits. This is because, once disease occurs and no truly effective treatment is available, it is simply too late. Unfortunately, for most of the noninfectious diseases, the results of treatment are problematic, whether given early or late.

Major exceptions are cancer of the cervix, for which early detection has proved dramatically effective and, to a lesser extent, cancer of the breast, for which secondary prevention is still not feasible on a large scale because of the high costs of mammography and medical examination.

Beginning in 1950, dramatic breakthroughs occurred in the epidemiology of the noninfectious diseases. During the next three decades, our epidemiologists forged powerful weapons to combat most of the major causes of death. In doing so, they initiated a second epidemiologic revolution which, if we act appropriately, will result in an enormous reduction in premature death and disability.

Heart disease, the first cause of death, results from high serum cholesterol caused by a diet rich in saturated fat and cholesterol, high blood pressure, cigarette smoking, and lack of physical exercise. All of these are amenable

They initiated a second epidemiologic revolution which, if we act appropriately, will result in an enormous reduction in premature death and disability.

to public health action programs. Cancer is the second major cause of death. Ideologic agents have been discovered for some of the most important cancer sites. These include radiation, as well as tobacco, alcohol and many other chemical carcinogens. All of these are amenable to public health action programs, based on the epidemiologic triad: that is, preventing the agent from reaching the host through the establishment of environmental barriers.

Cerebrovascular disease, the third major cause of death can be effectively prevented by treating the risk factor, high blood pressure.

Accidents are the fourth major cause of death, but rank first in terms of potentially productive years of life lost. Furthermore, they are not accidental. Each type of so-called accident is the result of specific agent, host and environmental factors. Many of these can be eliminated through appropriate public health programs.

Chronic obstructive pulmonary disease, the sixth cause of death results almost entirely from cigarette smoking and is therefore preventable.

Chronic liver disease and cirrhosis, the eighth cause of death, is caused almost entirely by alcohol and is therefore also preventable.

Given this situation in which most of the leading causes of death are in large part preventable, the most important items on the public health agenda are perfectly clear. They are heart disease, cancer, stroke, injuries, chronic obstructive pulmonary disease and cirrhosis of the liver.

Canada was the first country to understand the implications of the new epidemiologic discoveries. In 1974, the Government of Canada published a remarkable document, *A New Perspective on the Health of Canadians, Nouvelle Perspective de la Sante des Canadiens,* written by Mark Lalonde, Minister of National Health and Welfare.

This was an achievement of which both French and English Canada can be very proud. Brilliantly conceived and written with the clarity and elegance that we associate with the French literary tradition, the Lalonde Report was and remains one of the great achievements of the modern public health movement. It is, to use the current vernacular, "a world-class document."

The Lalonde Report was the first official government statement of policy that recognized the beginning of a new era in public health.

The Lalonde Report was the first official government statement of policy that recognized the beginning of a new era in public health, the era of the second epidemiologic revolution, which - just as the first epidemiologic revolution countered infectious diseases - will during the next few decades achieve the conquest of some of the most important noninfectious diseases. The report not only proclaimed this recognition to the world at large, but provided a conceptual basis for analyzing health problems and charting the approaches needed for their solution.

It is to the great credit of the Lalonde Report that it did not stop at the conceptual level, but actually delineated the specific measures that can be taken. The report is, therefore, not only a major contribution to public health theory, but an indispensable guide to action. The report proposed five strategies.

- A health promotion strategy.
- A regulatory strategy.
- A research strategy.
- A health-care efficiency strategy.
- A goal-setting strategy.

Not only were these general strategies proposed, but the report listed some possible courses of action for each of the strategies. A total of 74 specific actions were listed.

The goal-setting strategy included, among others, the following.

- The development of specific reductions in the incidence of major mortality and morbidity.
- The establishment of specific dates by which reductions in mortality and morbidity ought to be achieved.
- The development of specific improvements in the efficiency of the health care delivery system including improvements in cost performance, accessibility of care and the effectiveness of results.
- The establishment of specific dates by which improvements ought to be achieved.

Curiously, the Canadian government did nothing to carry out these goal setting actions. I use the term "curiously" because the Government of Canada had seen fit to inaugurate the national medical care program by granting the provinces 50 percent of the costs incurred. Surely the precedent existed for similar action for preventive services. Furthermore, the cost would have been infinitesimal, when compared with the massive expenditures for the medical care program.

Curiously, the Canadian government did nothing to carry out these goal setting actions.

Whatever the explanations for the failure of the government to act, the fact is that the Lalonde Report was almost totally disregarded in Canada. It had a great impact on public health workers in the United States, however.

Within five years, in 1979, Dr. Julius B. Richmond submitted the first Surgeon General's report on health promotion and disease prevention.

The Lalonde Report was almost totally disregarded in Canada.

That report, *Healthy People*, reviewed present preventable threats to health and identified 15 priority areas in which, with appropriate actions, further gains can be expected over the decade. The report established broad national goals, expressed as reductions in overall death rates or days of disability, for the improvement of the health of Americans at the five major life stages.

In the fall of 1980, the Surgeon General issued a second report, *Promoting Health, Preventing Disease: Objectives for the Nation*, which established specific and quantifiable objectives necessary for the attainment of these broad goals.

Objectives were established for each of the 15 priority areas identified in the Surgeon General's report: high blood pressure control, family planning, pregnancy and infant health, immunization, sexually transmitted diseases, toxic agent control, occupational safety and health, accident prevention and injury control, fluoridation and dental health, surveillance and control of infectious diseases, smoking and health, misuse of alcohol and drugs, nutrition, physical fitness and exercise, and control of stress and violent behavior.

What is Canada's health status? Canada today enjoys a relatively high level of health. During the 1970s significant improvement occurred. Overall age-standardized mortality declined by about 12 percent, reflecting primarily a 25 percent decline in ischemic heart disease and cerebrovascular disease.

Canada today enjoys a relatively high level of health...Overall age-standardized mortality declined by about 12 percent, reflecting primarily a 25 percent decline in ischemic heart disease and cerebrovascular disease.

This is approximately equivalent to the decline in the age-adjusted mortality rate for ischemic heart disease for the same period in the United States. It is less steep, however, than the approximately 35 percent decline in cerebrovascular disease in the U.S., a difference that probably reflects the impact of the relatively modest but effective campaign for hypertension control which was led by the U.S. Public Health Service in the '70s.

Unlike other cancer sites, cancer of the lung continues to rise in Canada, alarmingly so in women, for whom the rate doubled in nine years. Chronic obstructive lung disease and other major killers caused primarily by cigarette smoking is also on the rise in women. And cirrhosis of the liver, the result primarily of heavy alcohol consumption, increased by 31 percent in men and 21 percent in women during the '70s. Deaths from non-natural causes - accidents, poisoning, and suicide and homicide - showed small declines but continued to occur at a high level.

Cancer of the lung continues to rise in Canada, alarmingly so in women, for whom the rate doubled in nine years.

All of these diseases are preventable. Fifteen years after the publication of the Lalonde Report is long enough to wait before decisive action is taken. It would be a consummation devoutly to be wished if Canada were to act

now to set goals as called for in the Lalonde Report, including the following objectives for major causes of death, disability and illness. Canada might well adapt as its goal by the year 2000: mortality will be reduced from 1988 levels for ischemic heart disease by 40 percent; cerebrovascular disease by 50 percent; cancer by 10 percent; chronic obstructive lung disease by 15 percent; accidents, poisoning, violence by 20 percent and cirrhosis of the liver by 20 percent.

Canada might well adapt as its goal by the year 2000: mortality will be reduced from 1988 levels for ischemic heart disease by 40 percent; cerebrovascular disease by 50 percent; cancer by 10 percent; chronic obstructive lung disease by 15 percent; accidents, poisoning, violence by 20 percent and cirrhosis of the liver by 20 percent...These goals are achievable.

These goals are achievable. Even without a concerted public health campaign, age-adjusted mortality from ischemic heart disease and cerebrovascular disease declined by 25 percent in nine years. The other goals are modest enough in view of the effective preventive measures available for our use.

The proposed goals for mortality are not limited to this parameter. They hold also for morbidity - that is, for illness and disability - as well as for death.

The approximate 25 percent decline in age-adjusted mortality for cerebrovascular disease did not result from improvements in the treatment of cerebrovascular disease from 1970 to 1979, for no such improvements occurred.

The approximate 25 percent decline in age-adjusted mortality for cerebrovascular disease did not result from improvements in the treatment ...The cause of the decline was increased public and professional awareness,

Clearly, the cause of the decline was increased public and professional awareness, resulting in better case finding of hypertension, the increased use of antihypertensive drugs and the more effective maintenance of hypertension treatment and control. This was primary prevention of cerebrovascular disease. Not only mortality was affected, but incidents as well.

Similarly, primary prevention was mainly responsible for the approximately 25 percent decline in age-adjusted mortality of ischemic heart disease in the '70s. In view of the fact that 60 to 67 percent of deaths from myocardial infarction occur outside of hospital, while improvements in medical and surgical therapy have been shown to exert only a moderate effect on survivorship, treatment cannot be considered to have played a major role in the decline. On the contrary, all of the evidence points to risk factor changes as the most important element in this unprecedented reduction.

Primary prevention was mainly responsible for the approximately 25 percent decline in age-adjusted mortality of ischemic heart disease in the '70s.

During the coming period, we shall lower mortality, not only from cerebrovascular disease and ischemic heart disease, but from accidents, poisoning and violence; from lung and other cancers caused by tobacco, alcohol and other environmental and occupational carcinogens; from cirrhosis of the liver; and from chronic lung disease caused by cigarette smoking and by the occupational exposures of miners, textile workers, grain workers and others exposed to harmful dust. We shall also be effective in reducing mortality from a variety of other diseases caused by toxic chemicals and other environmental and occupational hazards. These

victories will be accomplished by primary prevention, by methods, which unlike medical care, reduce incidents as well as mortality.

We shall also make effective use of screening programs to discover cervical and breast cancer in their presymptomatic stage, thereby also preventing illness as well as mortality.

Implementation of these preventive measures is not only a question of achieving a higher level of health for the Canadian people, but of achieving equity in health. Just as the Canadian National Health Insurance Program was established to ensure equity in medical care, so must the same be pursued in the more fundamental goal of improving health status.

The available evidence indicates that both in the United States and Canada, lifestyle modification has been more effective in the more highly-educated groups. Canadian data on smoking prevalence is strikingly illustrative of this fact. Smoking cessation has occurred primarily among the most highly educated.

Lifestyle modification has been more effective in the more highly-educated groups. .. Smoking cessation has occurred primarily among the most highly educated.

It is essential, therefore, that every effort be made to reach the less highly educated groups that comprise the majority of the Canadian population in order to make certain that WHO's Alma Ata pledge of Health for All by the year 2000, to which Canada is a signatory nation, is indeed fulfilled for all the people of Canada.

This will require a sustained and well-funded campaign led by Canada's local, provincial and national health departments. "Well-funded," in this case, requires only a small fraction of the many billions of dollars which Canada now spends for the treatment of these preventable diseases. All that is needed is the political will to achieve these objectives.

All that is needed is the political will to achieve these objectives.

I want to talk about Canadian perspectives. At the International Conference on Health Promotion held in November, 1986 in Ottawa, the Canadian Minister of National Health and Welfare emphasized three leading strategies for health promotion.

- Fostering public participation.
- Strengthening community health services.
- Coordinating healthy public policy.

He went on to state: "Community health services are already playing an indispensable role in preserving health. We believe that there should be an expansion of this role and that it should be expressly oriented toward promoting health and preventing disease. At the same time, we recognize that adjusting the present health care system in a such a way as to assign more responsibility to community-based services, means allocating a greater share of resources to such services."

In his conclusion, however, the minister appeared to retract his commitment to allocating the greater share of resources to such services. He said, "We are aware that there are certain dilemmas inherent in health promotion." And then he went on to say, "Secondly, there is the question of allocating resources during times of scarcity. The availability of financing is obviously a critical question for each of us."

To my knowledge, the Government of Canada has so far failed, not only to develop a national strategy for strengthening community health services oriented toward promoting health and preventing disease, but it has not made any plans for a federal program of grants to the provinces for this purpose.

To my knowledge, the Government of Canada has so far failed, not only to develop a national strategy for strengthening community health services oriented toward promoting health and preventing disease, but it has not made any plans for a federal program of grants to the provinces for this purpose.

I fear that we are seeing a repetition of the previous failure to implement the 1974 Lalonde Report. The present government appears to be taking the same role, failing once again to provide the necessary financial support for health promotion and disease prevention.

In the United States, the Association of States and Territorial Health Officials (ASTHO), with the support of other major health organizations, has proposed that Congress enact a National Health Objectives Act. This calls for federal aid to state health departments to ensure a concerted national effort to reach the nation's health objectives for the year 2000.

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ASTHO is recommending an initial funding level of four dollars per person for a total of $1 billion for an estimated 1990 population of 250 million. Of the total national health expenditures of about $500 billion in 1987 in the U.S., only three percent was for government public health expenditures. Medical care accounted for 94 percent. The ASTHO proposal would add less than one-fifth of one percent to total health expenditures in the United States.

ASTHO is recommending an initial funding level of four dollars per person for a total of $1 billion for an estimated 1990 population of 250 million.

For the Canadian population of about 26 million, total medical care expenditures in 1987 were about $40 billion U.S. or $50 billion Canadian.

Initial federal grants to the provinces of $4 U.S. or $5 Canadian per capita to achieve Canadian health objectives for the year 2000 would, given an estimate of less than 30 million Canadians in 1990, cost less than $150 million Canadian.

Initial federal grants to the provinces of $4 U.S. or $5 Canadian per capita to achieve Canadian health objectives for the year 2000 would, given an estimate of less than 30 million Canadians in 1990, cost less than $150 million Canadian.

Since Canadian medical care expenditures will undoubtedly be greater in 1990 than the $50 billion Canadian estimated for 1987, the initial health promotion and disease prevention expenditures would come to less than three-tenths of one percent of total medical care expenditures.

Can Canada afford this infinitesimal initial expenditure for health promotion and disease prevention? The answer, obviously, is yes. Indeed,

the expenditure will more than pay for itself, since it will sharply reduce morbidity and the need for medical care spending.

Where should this initial expenditure come from? I propose taking it from the medical care budget; it will hardly be missed. I also propose that it be used almost entirely for disease prevention, since this is much less expensive than health promotion and will bring rapid results in lowering morbidity and thereby lowering medical expenditures.

Funds for health promotion - for housing, education, employment, adequate incomes, nutrition, improved recreational and cultural opportunities - require massive shifts in government spending priorities. I propose that the funds needed for health promotion be taken from two sources.

The initial health promotion and disease prevention expenditures would come to less than three-tenths of one percent of total medical care expenditures. Can Canada afford this infinitesimal initial expenditure for health promotion and disease prevention? The answer, obviously, is yes.

I. The medical care budget. The Canadian medical care system is based on a fee-for-service payment of physicians. Both Canadian and U.S. studies have convincingly demonstrated that this method of payment produces unnecessary surgical and other procedures and represents an unnecessary drain on national resources.

Salaried group practice plans and community health centers have up to 40 percent lower hospitalization costs and 25 percent lower overall costs than fee-for-service programs, with equal or better results in terms of health status outcomes. If tomorrow the Canadian medical care system were to convert completely from solo practice fee-for-service to community health centers and health service organizations, the medical care budget would be lowered from $50 billion to less than $40 billion, an annual saving of at least $10 billion.

It is time, indeed, for the Government of Canada to carry out the Lalonde Report's health-care efficiency strategy, the objective of which shall be to help the provinces reorganize the system for delivering mental and physical health care so that the three elements of costs, accessibility and effectiveness are balanced in the interest of Canadians.

II. The military budget. In 1986-87, the military budget accounted for 8.4 percent of the total Canadian expenditures of $117 billion, or about $10 billion. In 1987, there also occurred a World Conference of Health Workers on Social Well-Being, Health and Peace, with 121 participants from 50 countries. They represented 53 health workers' trade unions; 12 public health associations, including the Canadian Public Health Association and the American Public Health Association; 13 professional organizations; four other national health organizations; and 12 international and regional organizations.

The conference adopted the Health Workers' Declaration on the Arms Race and the Threat of Nuclear War, which stated that: "The arms race has resulted in severe cutbacks in health services, in education, in nutrition,

in every aspect of human services. Deadly diseases continue to destroy and maim our children, our men and women, because safe water supplies and basic sanitation facilities are not available, because people have no access to medical services, because they are hungry and undernourished, because they are poor and illiterate and know little of personal hygiene."

The conference recommendations included the following statement: "We fully endorse the United Nations General Assembly recommendation for a 10 percent reduction in the military budgets of the permanent members of the Security Council and allotment of 10 percent of the funds so released for assistance to the developing countries."

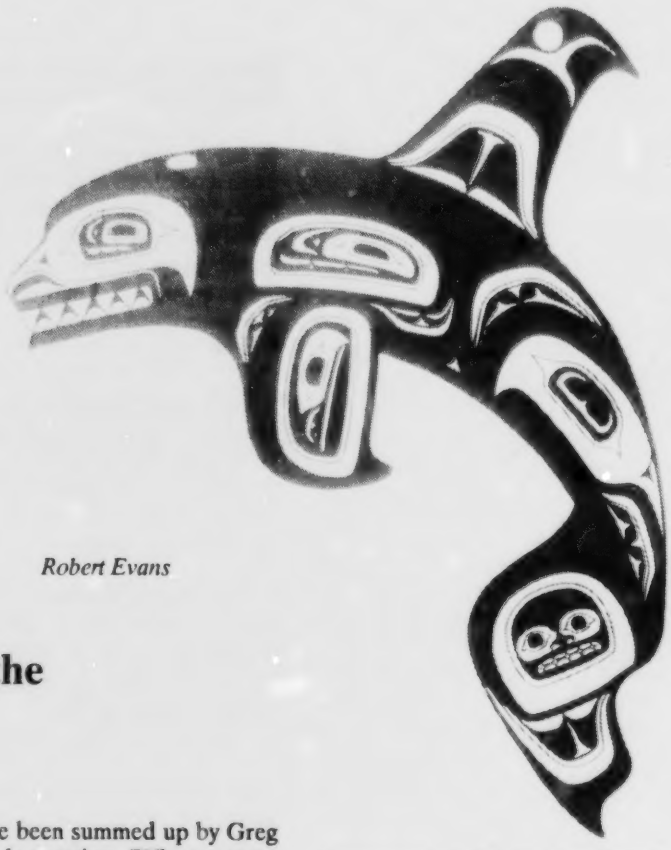
One result of the conference was the establishment of a World Council of Health Worker Organizations for Social Well-Being, Health and Peace. In January of this year, the International Coordination Committee of the World Council decided to extend the above recommendation to include all the nations of the world. Every country will be urged to reduce its military budget by 10 percent, and industrial countries will be asked to allot 10 percent of the funds so released for assistance to developing countries.

If the Canadian government were to accept this recommendation, $900 million would be available to fund health promotion in Canada.

If the Canadian government were to accept this recommendation, $900 million would be available to fund health promotion in Canada. Together with the funds available from reorganizing the Canadian medical care system, Canada could divert billions of dollars from basically unproductive uses - unnecessary surgical and other medical procedures and military expenditures - diverting these to productive, life-enhancing health promotion and disease prevention programs and to a better future for all Canadians.

BEHAVIOR AND BIOLOGY

Robert Evans



A Wider Perspective on the Health of Canadians

The whole thrust of this conference may have been summed up by Greg Stoddard at McMaster in the deceptively simple question: "Why are some people healthy and others not?"

"Why are some people healthy and others not?"

That question is both a call for action and an ethical question. There are market differentials in health, and that suggests that something should be done.

I don't disagree with that perspective, but my own is more that of the researcher. If there are these market differentials, then what causes them? What are the determinants? What are the underlying factors?

I want to go over some of the data on what we are calling heterogeneity in health status; and I want to draw some of the interesting inferences, both positive and negative, that seem to me to arise from that data. Secondly, on the basis of those inferences, I am going to suggest very tentatively a reorganization of the health fields that came out of the Lalonde Report. I think they have served us extremely well, but I think we need to try to order the boxes a little differently now.

Thirdly, I want to make some reflections on the role of the health care system arising out of my comments in the previous two sections.

In any human population, we find quite a substantial variation in health experience, both at any point in time and over the life cycle. It is extremely important, I think, not to get seduced into looking at that in terms of individual experience. The fact that each individual is unique is true and, for our purposes, irrelevant. It's a truism. It doesn't help us any. It doesn't get us anywhere. I may be saying the same thing Ilona Kickbusch said on the importance of not getting drawn into the discussion of individual risk factors.

What is more significant is that if you subdivide the population on some systematic basis - socioeconomic status, education level, income level, geographic region, gender - you find significant differences within those partitionings. In other words, it isn't just that each individual is different but that people are different systematically in ways that relate to their status on other dimensions.

We can now extend life without extending health.

For most of the statements I am going to make, my measure of "health" is life expectancy. There is more to health than life itself, but for most human populations most of the time, life expectancy is not a bad measure. We could generally agree that life is a necessary condition for health, even though it is not a sufficient condition, and even though we can now extend life without extending health.

One of the fundamental sources of heterogeneity is gender. The largest single differential that you get by partitioning the population on the axis of male-female is that females live, on the whole, longer than males.

Nobody seems to regard that as a suitable subject for equalization even though when we divide by socioeconomic status or by income, we find marked differences, and we say, "Dammit all, something should be done about that." If we divide by gender, we find larger differences and we say, "Well, that's the way life is: you don't have to standardize gender." That may be amusing, but it also raises the basic question, why?

The socioeconomic gradient in health status shows up across a very wide variety of different kinds of health care systems. That would lead one to suspect that maybe it doesn't have a lot to do with health care systems.

It is also true that females, on most of our measures, are sicker than males, so that the expectation of disability-free life expectancy for Canadian males and females is virtually the same, according to Adams and Wilkins. The difference is that females will live a lot longer and, apparently, be sicker. That also raises some fairly important questions.

The Black Report in England, which is probably the leading document on socioeconomic variations in health status, contains very important findings in several dimensions.

First, when you partition the population according to occupational and income and educational status, you find large differentials in life expectancy.

Second, you find the same thing in other countries: Canada, for example; the U.S.; Sweden; Japan. The socioeconomic gradient in health status shows up across a very wide variety of different kinds of health care systems. That would lead one to suspect that maybe it doesn't have a lot to do with health care systems.

This gradient is stable over time, or in the British case, even widening. We don't have a lot of intertemporal data, but we do have the Black Report, which says it is widening. That has a couple of implications. It reinforces the notion that the health care system may not have much to do with it because, first, the gradient didn't even flicker in response to the establishment of a National Health Service. Second, it hasn't been changed by a substantial increase in the volume of resources provided to health care in Britian.

There is another implication, which is that disease patterns have changed radically over the last 60 years. In previous generations, rich people died of cardiovascular diseases because they could afford the fat. Now, it's more likely to be a poor person's disease. But whatever people die of, the farther down the pole you are, the more you die of it. The diseases come and go, but the mortality gradient stays the same.

Disease patterns have changed radically over the last 60 years. In previous generations, rich people died of cardiovascular diseases because they could afford the fat. Now, it's more likely to be a poor person's disease.

That suggests the possibility that the diseases are simply epiphenomena; they are labels. Something more fundamental is at work in determining what causes people to live and what causes people to die.

Diseases are simply epiphenomena; they are labels. Something more fundamental is at work in determining what causes people to live and what causes people to die.

Do we find anything else like that? Yes, we do. We know that, although the socioeconomic gradient hasn't changed much, life expectancies and health expectancies have improved over time.

Does this have something to do with health care? Probably, but Tom McEwen has worked over the 19th and 20th century data and has shown that mortality patterns don't seem to be particularly sensitive to the introduction of therapy. If you look at the fall in tuberculosis, for example, there is a tiny blip toward the end which is the introduction of drug therapy for TB, but it is hardly of any great significance.

Something else was going on as populations became wealthier and had more living space. McEwen's explanation was nutrition. Other people would say public health. The trouble with public health is that the declines occurred both in the waterborne and non-waterborne infections. Furthermore, by the 1940s, most of the population had been exposed to TB but they didn't get TB anymore. One hundred years ago, they were exposed

to TB, and they got TB. Today they may have been exposed to the bacillus, but they don't get the disease, and why is that? We don't really know.

McEwen said "nutrition," but Leonard Segan in *The Health of Nations* argues on the basis of data from wartime populations that a cutback in our nutritional status is good for us - up to a point. You can starve people to death, and in Holland in the hunger winter, they came close; but in Denmark, in World War I, the population's nutritional status came down substantially, but their health went up.

So, we are back to that factor X again. What is it that underlies this pattern of mortality that doesn't seem to be readily explained by the usual sorts of arguments? Whatever this factor is, however, it is systematic. It is not something that is peculiar to the individual.

Psychologists have discovered that we suffer from a systematic bias when we try to draw conclusions under uncertainty and when we try to infer causality. When we observe different actors taking actions in the same circumstances, we systematically underestimate or disregard the fact that the circumstances are similar. There is a hard-wired bias in our thinking processes which leads us to disregard the circumstances and to focus on the observation that all the actors did the same thing.

We observe that people at lower income levels are much more likely to smoke, and we assume that they do it by choice. We disregard the blindingly obvious observation that all these people in the same circumstances do the same thing.

To put that in concrete terms, we observe that people at lower income levels are much more likely to smoke, and we assume that they do it by choice. We disregard the blindingly obvious observation that all these people in the same circumstances do the same thing. We seem to be hard wired to go back to the individual explanation.

Some very interesting data came out of a study of the U.K. Civil Service produced by Michael Marmot, who has looked at the civil service there as a pure type of hierarchy. The subjects in this study are well above the poverty line. Nobody is deprived. Nobody is short of food. They are all working behind desks; they're all living in London; and they're all doing similar sorts of jobs. Yet, there is a well-defined gradient of mortality, and it is a gradient; it's not a step function.

The administrative grades at the top live longer than the executive grades just below them. The executive do better than the clerical; and the clerical do better than the rest. There is a smoking differential, but the differential in mortality shows up for diseases that, as far as we know, are not related to smoking.

The data on the connection between social relationships, social support networks and health is as solid as the data on smoking and health was in the early 1950s.

So, what is going on here? This sort of observation has led people like Lynn Syme at Berkeley to talk about notions of control, notions of coping with your environment. Other people have been looking at the way in which the pattern of social relationships affects health status. James House at Michigan now claims that the data on the connection between social

relationships, social support networks and health is as solid as the data on smoking and health was in the early 1950s.

But there is a real problem if we accept the implications of these sorts of data on heterogeneity, and I'm going to suggest that we can't avoid at least confronting them. But the implications are a little awkward, and that is what I am going to discuss in the second part of my talk.

First though, I want to flag one other thing. If we look at Japan today, we would find rapid increases in health status: life expectancy increasing rapidly; infant mortality way below the Swedes and getting better, and it seems to be correlated with some kind of rapid increase in wealth, some kind of rapid sense of national coping ability - a general sense of feeling good about one's self.

If we look at Japan today, we would find rapid increases in health status: life expectancy increasing rapidly...and it seems to be correlated with some kind of rapid increase in wealth, some kind of rapid sense of national coping ability - a general sense of feeling good about one's self.

In Japan, people are getting rich, but they don't even spend the extra money on consumption. They are busy reinvesting it all. They are certainly not spending it on health care; they are one of the low spenders in the OECD. And yet, the health statistics keep on getting better. And this raises some interesting questions.

I mentioned the coping aspect. Lynn Syme has some interesting data from the U.S. Head Start Program which subjected pre-school kids to a lot of interventions to try to give them a head start in dealing with school. It didn't have much effect on their school performance, but when the same kids were evaluated relative to random controls 20 or 15 years down the line, they turned out to have less illness, less crime and less significant differences in their ability to cope with life as a result of that very early life education.

There is a lot of evidence to suggest it is not just a question of poor people who don't have enough to sustain life. It's a question of a gradient pattern which applies across the whole population. And it's not just food; maybe it isn't food at all. It's certainly not medical care; it is not just public health in the usual sense. We are not sure what it is, but whatever it is seems to be pretty important.

Now, why does that lead us to think about reorganizing Lalonde's fields? The important thing about this new information is that the pathway and the agent are no longer intimately connected.

The important thing about this new information is that the pathway and the agent are no longer intimately connected.

If you think about Lalonde's fields - lifestyle, tobacco - the agent and the pathway are pretty clearly hooked together. You smoke; the tar gets into your lungs through mechanisms that are not fully worked out; the tar generates cancerous cells in the lungs.

If you fail to fasten your seatbelt, we know pretty clearly what will happen if you have a collision. Again, the pathway is not very ambiguous. The same could be said for alcohol. The same could be said for all lifestyle behaviors in the areas of choice. Now, think about differences in health status which

are related to whether you have a close friend or not. Or the differences in health status which are related to whether you are an executive or a clerical or administrative grade in the U.K. Civil Service. These differences are real. They are statistically significant. What are the pathways through which those processes work?

Well, they are totally unknown, but there are some interesting hypotheses floating around. You may have run into the notion of psychoneuroimmunology. It turns out, I am told, that the cells in the immune system have receptors on their surfaces for neuropeptides produced by the brain.

That means you could communicate directly with your immune system, if you only knew how. Other chaps have found that nerve endings tend to grow towards mass cells which, in turn, respond to various kinds of injury or infection: another direct connection between the nervous system and the immune system.

In the data from his U.K. Civil Service study, Marmot is looking at the amount of fibrinogen protein circulating in the bloodstream; this is a protein associated with repair of injury. The notion is that when you are under some form of stress, when you are down in the hierarchy and people are stomping on you a lot, your body responds by preparing to repair injuries that aren't there; as a result you have fibrinogen protein circulating around, which may have something to do with your cardiovascular disease.

Well, maybe. These are all possibilities, very far from anything you could call proof at this point, but pretty fascinating as possible links in the relationship between your position in a social hierarchy and your probability of having heart disease.

Also, note what this says about stress. Many of you will have run into the notion of good or bad stress. It is highly stressful to be asked to give a talk on a subject that you don't know nearly as well as you would like to, to a distinguished group such as this one. The only reason I am able to cope with this stress without severe damage to my health, is that I know I'm just so good that I can do it. I think the parallel with the administrative grades of the civil service is close.

We have to break down the barriers between the boxes of biology, environment and lifestyle, because they aren't separate.

On the other hand, if you are in circumstances where you can't control your environment; where the stress patterns come at you and you don't really know when or where, and you don't know how to deal with them; or you're not sure that you're going to deal with them and people beat on you all the time, that apparently is a good deal more destructive, in a direct and physiological sense.

What does this have to do with Lalonde? It means that we have to break down the barriers between the boxes of biology, environment and lifestyle, because they aren't separate.

In fairness to the authors of the Lalonde document, I think they were well aware of that because they called them fields not boxes. But the trouble is that once you have a field, somebody is going to come along and build a fence around it. Once you've got a fence around it, you're pretty close to being in a box. I think that's exactly what happened with the lifestyle concept that came out of Lalonde. It started off as a general statement about the way in which behavior relates to health outcomes, and the next thing you knew, it became a justification for blaming the victim.

There is a distinguished economist in the U.S. who has concluded that people get sicker because they have a low rate of time preference. That is exactly the same as the Victorian concept of the poor as improvident. They don't look after themselves, and so they get sick, and what can you do about it? It's just nature's way.

You wonder what on earth is going on in that kind of mentality. What is going on is a shift from talking about lifestyles to talking about individual choice and then to the consequences following strictly from that choice. But we need to think about a continuum of organism responses. At one end of the continuum, we can have the responsiveness of the immune system, and at another end of the continuum we can have the response of fastening your seatbelt.

What is going on is a shift from talking about lifestyles to talking about individual choice and then to the consequences following strictly from that choice. But we need to think about a continuum of organism responses ... conditioned by environment rather than a sharp distinction between lifestyle, environment and biology.

The notion that there is a sharp distinction between one of these responses as biological and the other as lifestyle is wrong, because your immune system is affected by your social environment. I'm even told that there are very practiced meditators who can control their antibody titre by meditation. It sounds a little far out to me, but it's a big world out there.

It is clear that there is increasing evidence of some kind of connection between the brain and the immune system on the one side; and on the other side, it's clear that fastening your seatbelt, smoking and drinking and so on, are not decisions taken in isolation from your social environment.

So we have a continuum of organism responses conditioned by environment rather than a sharp distinction between lifestyle, environment and biology. The whole game has become, I think, substantially more complex.

Now, it doesn't follow that you can throw off massive infections by sitting there and thinking hard about it, and I'm not trying to pretend that. There is always the danger that this will become yet another part of the "blame the victim" story. If you got sick and couldn't throw it off, it was because you had bad attitudes or it was something you were feeling guilty about. This is not what we are talking about, and yet it is equally at risk of being converted into that kind of story.

At this point, all I'm saying is that I think we have to see the interaction between biology and lifestyle as part of a basic way in which the organism

responds to a complex environment. The environmental issues are more complex than whether there is crud in the air or in the water or whether there is a car coming at you and things like that.

Those are not unimportant, but they are only part of a much larger story that we don't yet understand. Furthermore, there is a time line to this whole thing; it evolves over the life cycle. Your vulnerability to effects on your learned coping skills, your learned powerlessness, is very different at different stages in your life cycle. I don't think anybody has that all plotted out yet, but it is quite clear that very early life is a strategic time.

Your vulnerability to effects on your learned coping skills, your learned powerlessness, is very different at different stages in your life cycle.

All this suggests that the Lalonde four-field concept needs to be reformulated as two octagonal continua, one in the consciousness domain and one in the time domain. The consciousness domain is everything between your physiological processes and whether or not you fasten your seatbelt; the time domain operates over your life cycle, starting probably with pre-conception and continuing until sometime after the age of 40.

Where does the health care system fit into all of this? The relationship between health and the health care system is now distinctly problematic. There is an argument that the rapid and major expansion in health care activities in our society has not had much to do with the kind of gradients that I am talking about. But finding that the glass may be half empty should not blind us to the fact that it is also half full.

Where does the health care system fit into all of this? The relationship between health and the health care system is now distinctly problematic.

We can't, either in terms of political feasibility or in terms of our ultimate objectives, simply say, "Let's forget about the health care system and get on with providing health through some other mechanism," or change the world.

I think we do have to change the world. I feel very uncomfortable confronting the kinds of things that Ilona Kickbusch was bringing up, but I think she is probably right that over the long-run those issues really are pretty fundamental.

Coming back to the kinds of coping and factor X issues that I was mentioning before, Japan and the U.K. both spend about the same share of their national resources on health care, and in the U.K. the health indexes are not looking that good. They are not going into a nose-dive the way they are in Eastern Europe, but they aren't nearly as impressive as they would have looked 10 years ago relative to the rest of the world.

The Japanese, on the other hand, are moving out in front quite fast. They are mobilizing their resources for economic growth. It gets a little touchy here because I am starting to suggest that national success in economic growth may be positive for your health. Yet it has all kinds of negative feedback, and I'm not sure how we reconcile those sorts of things.

Whatever you want to do - whether you want to mobilize your national resources for renovating your sewer system or for cleaning up after your

nuclear waste plants or for building new whiz-bang machines and gadgets for selling to people in the rest of the world - you have to find a way of mobilizing your resources for investment.

Whatever you want to do - whether you want to mobilize your national resources for renovating your sewer system or for cleaning up after your nuclear waste plants or for building new whiz-bang machines and gadgets for selling to people in the rest of the world - you have to find a way of mobilizing your resources for investment.

If you are dissipating all your resources on consumption activities, which the Japanese are not doing, then you will not be able to do whatever it is you want to do. You are going to have a rough time being on the front edge of any of those national objectives if you are using all your resources to prolong the life of people in the last three or four years of their lives.

In our health care system and in the U.S. and in most of Western Europe, an increasing share of our health resources is being devoted to prolonging the dying process. That raises some very profound ethical issues, separate from the equally important ones about the amount of effort going into doing things that just don't do anybody any good at all.

There are two levels on which we have to worry about the health care system. One is that it is sucking in resources, and on that subject, I think everybody should read the book *Second Opinion*. Beyond that, we need to worry about the way the health care system is using resources for things that don't have any payoff and things that are clearly part of the consumption demand.

Perhaps the most important difficulty we have with the health care system is that it absorbs our time, our attention and our very scarce resources of thought and communication. I think perhaps all of the things Milton Terris was saying and all of the things Ilona Kickbusch was saying depend absolutely critically on getting this information out to the general public and on freeing our political masters to take the kinds of decisions which we tell them that they ought to take.

We need to worry about the way the health care system is using resources for things that don't have any payoff and things that are clearly part of the consumption demand.

They can't do those things in an environment where nobody who votes understands what they are talking about, and we can't communicate that kind of information when the whole area is being blanketed by debates about why we need more money for cardiovascular surgery for people in their eighties.

The scarce resource which the health care system is tying up is our ability to think about and communicate what the real health care issues are.

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PROVINCIAL REPORTS

British Columbia: Pat Wolczuk

The British Columbia Minister of Health recently appointed an Advisory Committee on Health Promotion with a mandate to recommend new approaches that will produce sustained change in the health status of British Columbians.

The Advisory Committee has developed a conceptual framework for health promotion that recognizes health as a resource for every day living, rather than an end point. In this perspective, health as a resource for everyday living is the context in which health promotion activities take place.

The Advisory Committee on Health Promotion has stressed the establishment of specific *goals* and *objectives* for improved health that are both achievable and measurable: for example, reducing the potential years of life lost to cardiovascular disease. These objectives will change over time, as will the specific self-selected targets of individuals, families, geographical communities, and communities of interest.

The Advisory Committee on Health Promotion has stressed the establishment of specific goals and objectives for improved health that are both achievable and measurable.

The Committee also identified six *challenges* that identify broad areas where change is needed. The following challenges can be seen as either hurdles to overcome or opportunities for advancing health promotion.

- Shifting our thinking about the health care system to the broader concept of a health system and clarifying the extent of our control over our own health.

- Reducing inequities in factors such as education, income, ethnicity and geographical location.
- Decreasing environmental risks.
- Creating supportive environments.
- Enhancing behaviors that have positive effects on health.
- Reducing behaviors that have damaging effects on health.

Nine kinds of strategic action will be needed to address these challenges and accomplish specific objectives. These *action strategies* are:

- Identifying and analyzing health issues.
- Advocating for health.
- Building new partnerships.
- Enacting healthy public policy.
- Providing for the needs of special communities.
- Strengthening local actions.
- Supporting personal skills development.
- Fostering mutual aid.
- Developing an infrastructure for health promotion.

Some examples of these strategies are media support for anti-drinking and driving campaigns (advocating for health); a workplace or school making the decision to ban smoking (enacting healthy public policy); the Healthy Communities Project (strengthening local action); or a prenatal outreach program (providing for the needs of special communities).

The choice of strategy depends on the specific objective, the challenges, the available resources and the capacity of those affected by the decision, whether it be the public, the professionals, or the political players.

In any particular situation, the choice of strategy depends on the specific objective, the challenges, the available resources and the capacity of those affected by the decision, whether it be the public, the professionals, or the political players. All of the stakeholders must be involved in the process of analysis and planning that precedes action.

For example, a community may choose the reduction of traffic accidents as a healthy objective. They might identify a shift in thinking about the acceptability of drinking and driving as one of the challenges affecting this issue. They might also see a need to provide more supportive environments to motivate less risky behavior.

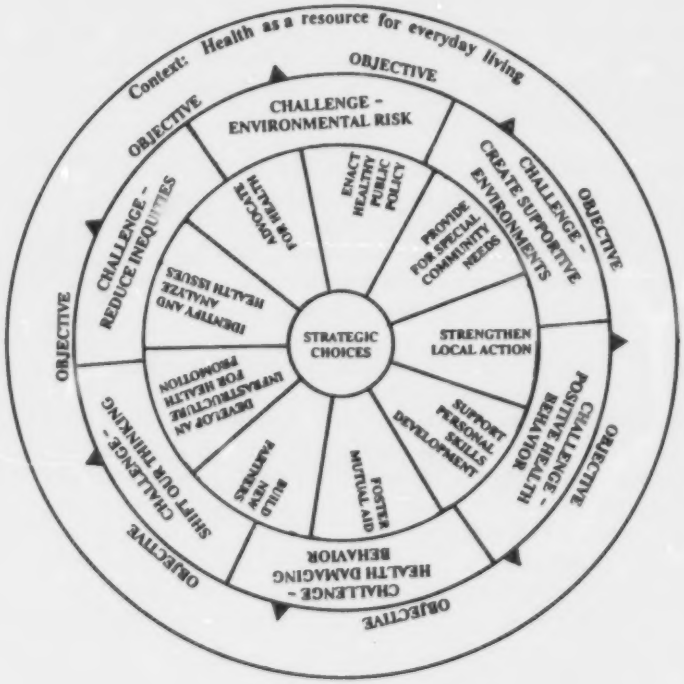
Accomplishing the objective would require analyzing the root causes of traffic accidents, and this might lead to convincing the City Engineer to advocate for safer intersections. Health professionals might offer skill development programs aimed at improving alcohol habits, and local sports teams might decide to re-examine the emphasis on alcohol in victory celebrations.

This is only one example of the way this model might be applied in a particular situation. The model is a dynamic framework within which the specifics of objectives, challenges and appropriate strategies may change, depending on the circumstances and the communities involved. However, the view of health as a resource for living remains constant.

The Report of the Minister's Advisory Committee on Health Promotion used this model as a basis for a series of recommendations for future action in British Columbia.

These recommendations included the establishment of an Office of Health Promotion and targets for the reallocation of health dollars from hospitals to community-based projects.

A CONCEPTUAL FRAMEWORK FOR HEALTH PROMOTION


Context: Health as a resource for everyday living
OBJECTIVE
CHALLENGE - ENVIRONMENTAL RISK
CHALLENGE - CREATE SUPPORTIVE ENVIRONMENTS
CHALLENGE - POSITIVE HEALTH BEHAVIOR
CHALLENGE - HEALTH DAMAGING BEHAVIOR
CHALLENGE - SHIFT OUR THINKING
CHALLENGE - REDUCE INEQUITIES
ENACT HEALTHY PUBLIC POLICY
PROVIDE FOR SPECIAL COMMUNITY NEEDS
STRENGTHEN LOCAL ACTION
SUPPORT PERSONAL SKILLS DEVELOPMENT
FOSTER MUTUAL AID
BUILD NEW PARTNERS
DEVELOP AN INFRASTRUCTURE FOR HEALTH PROMOTION
IDENTIFY AND ANALYZE HEALTH ISSUES
ADVOCATE FOR HEALTH
STRATEGIC CHOICES

Alberta: Marc Gallop

A challenge paper, *Moving Into the Future for the Health of Canadians,* was released in March 1988 by the Honorable Jim Dinning, Minister for Alberta Community and Occupational Health. *Moving Into the Future* presents major trends and issues that affect health programs, individual health and the health of the community. It is intended to stimulate thought and discussion among decision makers, the boards of community health services and interested members of the public.

The Government of Alberta has recently formed the Premier's Commission on the Future Health of Albertans, whose mandate is to make recommendations for changes in the health system.

In addition, the Government of Alberta has recently formed the Premier's Commission on the Future Health of Albertans, whose mandate is to make recommendations for changes in the health system. The commission is expected to submit its recommendations to the Premier in the fall of 1989.

The document *Moving Into the Future* starts from a premise established by Canada's Health Promotion Survey: that there is a significant gap between people's awareness that they should do something to improve their health and their actual behavior. The challenge is to find new ways to turn interest in health into firm intentions and to turn those intentions into new, healthier habits.

Creative new strategies are needed to encourage individuals, families and communities to make the healthy choice the easy choice and to act on what they already know to improve health in their communities.

The importance of health promotion lies in the fact that so many of our problems, both today and increasingly in the future, are related to personal choices about the way we live our lives. Creative new strategies are needed to encourage individuals, families and communities to make the healthy choice the easy choice and to act on what they already know to improve health in their communities.

Alberta already has a strong foundation for health promotion in its extensive network of groups and services operating at the grassroots, community level. The challenge is to mobilize this grassroots energy around a coordinated effort based on strategically targeted, province-wide health promotion and prevention priorities. Current efforts to achieve this are concentrating on cardiovascular health.

Alberta has a decentralized system of health promotion delivery that includes 27 autonomous local health units, most of which have a Health Promotions Programs Manager on staff. In future, the role of these health units will expand to include some coordination of local program delivery in areas such as Healthy Communities programming and heart health.

In community settings such as schools, workplaces and health-related agencies, health promotion initiatives are coordinated around four basic themes.

- People helping themselves and each other.
- People working together as a community.
- People building a healthy environment.
- Public policy which recognizes health as a priority.

These principles are demonstrated in a number of programs summarized in two recent reports from the Department of Community and Occupational Health: *Health Promotion Programs in Local Health Units* and *Health Promotion Programs across the Alberta Government.*

Other efforts to improve coordination have focussed on encouraging more cooperation among existing agencies involved in health service delivery and also among groups such as urban planners, architects, business leaders and politicians, whose activities are not usually considered health related.

Examples of this are:

- A conference on health promotion sponsored by a joint committee of the Alberta Hospital Association and the Health Unit Association of Alberta.
- A new concern about healthy public policy among Alberta municipal councils, as indicated by their interest in the healthy communities project, "Vision 20/20."
- The Premier's Commission on the Future Health of Albertans, which has been holding town hall meetings across the province.

Several practical benefits have resulted from efforts to achieve more coordination of community-based programs and more cooperation among a broader spectrum of participants. These benefits include increased resources targeted to health, some major multi-disciplinary programs that will be effective in changing behavior, and a stronger central voice speaking on behalf of health promotion agendas in Alberta.

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Manitoba: Ulrich Wendt

Preventing chronic diseases such as heart disease is an increasingly important focus of health promotion programs in Manitoba.

Preventing chronic diseases such as heart disease is an increasingly important focus of health promotion programs in Manitoba. These programs are based on a growing awareness that the leading causes of death - heart disease, cancer, chronic respiratory disease and accidental injuries - are largely preventable.

For example, at least 80 percent of the population consume a diet that is sufficiently high in fat to increase the risk of heart disease and cancer; over 50 percent have unhealthy weights; almost half the population does not get regular exercise; and in spite of our efforts to discourage smoking, almost 30 percent of Manitobans are regular smokers.

Although changing individual behavior is important, the health promotion community in Manitoba is also beginning to recognize the significance of other factors such as the health care system, the physical and socioeconomic environment, the network of government programs and policies, the willingness of people and communities to work together for change, and the power that people have to affect change.

Health is influenced by the complex interaction of a number of factors beyond human biology and lifestyle choices. Manitoba is now beginning to address some of these other issues.

One element in this new direction is a concern for healthy public policy. This is expressed in the creation of a Healthy Public Policy Committee of Cabinet with a mandate to coordinate government policies, programs and legislative initiatives that have an impact on health status.

The Manitoba Minister of Health has created a new health advisory network comprised of a wide range of people who are external to government but interested in health services and policy.

In addition, the Manitoba Minister of Health has created a new health advisory network comprised of a wide range of people who are external to government but interested in health services and policy. The network will be an avenue for community input into the policy development process.

A second element of the new strategy is a coordinated electronic and print media campaign to raise the public profile of health promotion issues. This campaign will enlist well-known public figures as health promotion ambassadors and target specific at-risk groups such as adolescent males.

In the area of intersectoral cooperation, Manitoba regional public health staff are mobilizing municipalities to become partners in health promotion in accordance with the healthy communities concept. Partnerships with non-government agencies are also part of the strategy. Examples include program links with seniors organizations, the Canadian Diabetes Association, the University of Manitoba, provincial marketing boards, the

Alcoholism Foundation and other government departments such as agriculture.

A new initiative will also promote closer links with business and industry through grants for work-site health promotion programs. A recent pilot project at the Canadian National Railway yards in Winnipeg indicated a good chance for future success with this approach.

The goal of these initiatives is to aid in the development of an environment which will give people the tools to be able to take more responsibility for their own health and improve the health status of all Manitobans.

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Ontario: Bob MacMillan

The Ontario government has demonstrated its firm commitment to health promotion by taking positive and substantive action to encourage and facilitate health promotion activities. In addition, Ontario has embraced the World Health Organization's concept of health promotion as the process of enabling people to take control over their own health.

Three influential reports came out in Ontario in 1987.

- The report of the Ontario Health Review Panel.
- The report of a panel on Health Goals for Ontario.
- The report of the Minister's Advisory Group on Health Promotion.

Health status is influenced by variables such as affordable housing, environmental protection, workplace safety, and literacy, which are outside the health care system.

These reports contributed to two shifts in thinking that are guiding Ontario's approach to health promotion. First is the recognition that health status is influenced by variables such as affordable housing, environmental protection, workplace safety, and literacy, which are outside the health care system. Second is recognition of the need to shift the emphasis within the health care system away from treatment and toward health promotion and disease prevention.

An important strategy for achieving this will be to enlist the aid of Ontario's physicians, who are the public's major source of health information.

An important strategy for achieving this will be to enlist the aid of Ontario's physicians, who are the public's major source of health information. However, the government will have to consider policy changes to bring that about: for example, adding health promotion to the services on the physicians' fees schedule.

The Ontario government has taken three major steps within the past two years to reshape the province's health care system.

I. Creation of the Premier's Council on Health Strategy. Council members include the premier (chairman), the minister of health (vice-chairman), other cabinet ministers, and 24 representatives from the fields of health, social services, business and labor, and the general public.

The council's mandate is to develop a long-term strategy for health and health care in Ontario. The mandate includes establishing specific health goals, identifying policy initiatives that emphasize health promotion and disease prevention and recommending ways to promote self-care. The council is preparing a document that will outline a vision of health and healthy goals for Ontario.

II. Creation of a Health Promotion Branch within the Ministry of Health to coordinate and integrate health promotion policy planning and service delivery.

The Ontario government has taken three major steps within the past two years to reshape the province's health care system:

In addition to its coordinating activities, the branch has initiated three new programs in the past year.

- The Heart Health Promotion Program will receive $1 million annually to support community-based efforts to prevent heart disease.

- A complementary initiative has been the launching of a major advertising campaign to encourage people to stop smoking, moderate their use of alcohol and adopt a low-fat diet. The theme is "Health, It's a Great Feeling."

Creation of the Premier's Council on Health Strategy...Creation of a Health Promotion Branch within the Ministry of Health...Developing new goals for Ontario's 43 public health units and instituting major changes to the mandatory core programs

The advertising campaign has a community component which will include how-to manuals and other resource materials, prototype programs for use at the local level, and staff assistance for community organizing efforts.

The branch also supports community health promotion initiatives through a grants program with a yearly budget of $1 million. To upgrade the level of information available to the community, the branch has given additional major funding to the Ontario Prevention Clearing House.

III. Developing new goals for Ontario's 43 public health units and instituting major changes to the mandatory core programs provided in the units. The result will be a "fresh new face" on public health in the province.

As a result of new programming and additional funding for health promotion, Ontario can look forward to the emergence of a new vision of health which stresses positive health habits in supportive communities.

Quebec: Marc Dionne

Since the early '70s, public health workers in Quebec have had close links with the community through the province's unique network of more than 150 multi-disciplinary local community service centers. The province's 32 municipal health units also have a mandate to provide health protection, health promotion and preventive services within their local area.

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At present, Quebec's twelve regional health and social service councils are working on establishing health service plans for their regions. These plans must include strategies for disease prevention and health promotion.

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The Department of Health and Social Services is in a period of transition as a result of the work of the Rochon Commission. The commission's evaluation of the Quebec health care system recommended that the provincial Department of Health shift its emphasis from administration of institutional services to formulating and directing the framework program.

The department's new policy initiatives are likely to include a health promotion action plan and the mobilization of intersectoral partnerships. The proposed action plan is based on the premise that health promotion is a process whose purpose is to improve health status by providing the individual and the community with more control over the factors that determine health. This concept recognizes that improving health requires changes in both lifestyles and living conditions.

Quebec's proposed health promotion action plan will emphasize the following areas: heart health, including nutrition, physical activity, and tobacco, alcoholism and other addictions; safe, responsible sex; prevention of traffic and other accidents; mental health; and self-sufficiency of the elderly.

Strategies associated with the action plan include support for the "Ville et Villages Sante" ("Healthy Cities") concept; the development of a project involving personal health files that will allow communities and individuals to monitor their health; and a symposium in the fall of 1989 to inform decision makers and communities about the growing social inequalities which are at the root of the health disparities in Quebec.

Strategies associated with the action plan include support for the "Ville et Villages Sante" ("Healthy Cities") concept.

In the area of heart health, specific initiatives will include an information and education program directed at reducing high blood pressure and hypercholesterolemia. Nutrition information will be designed for specific populations, such as young people, the elderly, and disadvantaged groups. In this connection, the school system in Quebec has recently adopted a new food policy designed to improve student nutrition.

A program called "Kino-Quebec," developed in collaboration with the Department of Recreation, Hunting and Fishing and other agencies, will promote access to physical activity. Another program called "Viactive" is already underway, with the objective of providing the elderly with the means to enroll in physical activities.

Attacks on tobacco abuse, alcoholism and other drug addictions will focus on increasing public information and awareness. In the case of tobacco, the plan also involves encouraging municipalities, health institutions and businesses to regulate the use of tobacco in their environments.

In preventing AIDS and other sexually transmitted diseases, the focus will be on providing young people with adequate information about safe, responsible sex. Preventing traffic accidents will involve collaboration between all levels of government.

In mental health, the emphasis is on deinstitutionalization and self-sufficiency. The concern about promoting mental health is supported by efforts to create favorable living environments and increase personal skills, especially parenting skills.

Self-sufficiency is also the objective of health promotion activities among the elderly.

As part of the "Villes et Villages Sante" project, 14 Quebec municipalities are working on health promotion activities in collaboration with other public agencies.

In its proposal for a new health promotion action plan, the Quebec Department of Health is moving firmly in the direction of using health promotion as a means of preventing socio-medical problems.

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Nova Scotia: Theresa Marie Underhill

Since 1987, the Nova Scotia Department of Health has been named the Department of Health and Fitness. This name change was part of a shift in focus in the department toward an aggressive, integrated approach to health promotion.

Two key factors were responsible for this new focus on health promotion: negative statistics regarding the current health status of Nova Scotians and recognition that preventive measures could have a positive effect on these statistics in the medium to long term.

In 1988, the department launched "The Healthy Lifestyle Promotion Program," a major health education initiative directed at encouraging individuals to take greater responsibility for their health status by making healthier lifestyle choices. The program addresses four target populations: youths, age 0 to 18; adult women, 19 to 34; adult males, 35 to 64; and seniors, 55 to 74. The main focus areas are heart health, nutrition education, smoking prevention and cessation, and physical activity or fitness.

As part of this program, an extensive multi-media public education and awareness campaign will stress the importance of healthy lifestyle choices, especially physical fitness, nutrition and smoking cessation.

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The Department of Health and Fitness is also proposing a no smoking policy for all departments and agencies of the provincial government. In addition, the department is developing smoking policy guidelines for schools and other worksites.

Community involvement and empowerment will play a key role in the Healthy Lifestyle Promotion Program. Major empowerment initiatives include a worksite health promotion program entitled "Wellness in the Workplace," with emphasis on fitness, smoking cessation, nutrition and stress management. A second initiative will focus on empowering patients in community-based cardiac rehabilitation programs by encouraging them to participate in a self-directed rehabilitation program.

A third initiative will promote healthy aging for young seniors. Programs will provide information about the aging process, diet and nutrition, mental health and physical activity. They will be delivered through liaison between community agencies and the community health nursing and nutrition divisions of the Department of Health and Fitness.

A fourth initiative in the area of empowerment is a program of grants to community groups to support proposals that promote the objectives of the Healthy Lifestyle Promotion Program.

Fitness is a key component area of the Healthy Lifestyle Promotion Program. Initiatives in this area will be designed to accomplish three objectives:

I. *Enhance the quality of services by developing leadership skills in the fitness community.* Methods for doing this include formation of a provincial community fitness advisory committee; implementation of a lifestyle leadership development program; and publishing a health and fitness newsletter which will be distributed to approximately 2,000 health and physical fitness professionals in the province.

II. *Encourage healthy lifestyles in the primary target populations.* Specific initiatives include "Wellness in the Workplace"; some aspects of the Nova Scotia Heart Health Program; healthy aging programs; community grants; and the "Healthy New You" promotion.

III. *Provide consultation to community groups and agencies on fitness and education programming alternatives and program implementation.*

Regional health units and local offices of the Department of Health and Fitness will be responsible for delivery of the Healthy Lifestyle Promotion Program initiatives and activities. Lifestyle educators will be hired within each unit to serve as a functional arm of the department.

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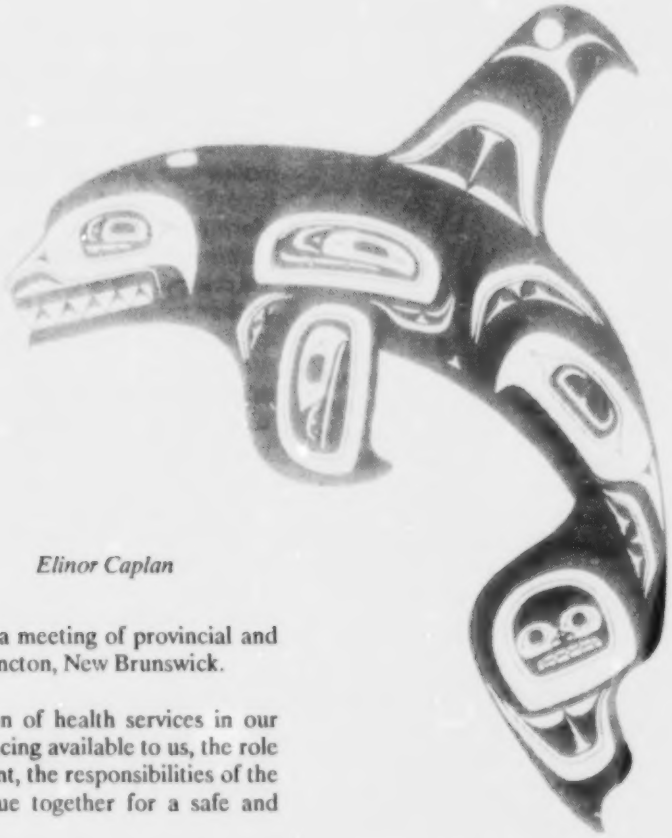
With the launching of the Healthy Lifestyle Promotion Program, the Nova Scotia Department of Health and Fitness is committed to the goal of making a meaningful and long-lasting impact on the lifestyle of Nova Scotians. The benefits of the program will include social, economic and personal gains, including greater self-confidence, increased potential for achievement and an overall improved quality of life.

SPECIAL REPORT

Elinor Caplan



Last month I had the privilege of attending a meeting of provincial and territorial health and finance ministers in Moncton, New Brunswick.

The focus of that meeting was the provision of health services in our respective provinces and territories, the financing available to us, the role and the involvement of the federal government, the responsibilities of the provinces, and the directions we can pursue together for a safe and confident health care future.

While the provinces and the territories brought their own perspectives and circumstances to the meeting, we were all grappling with a common agenda: how to provide the most effective range of health services to our people; how to provide health services in the context of sound financial management; and how to respond to the changing societal, demographic and technological factors that are having such a profound impact on health care today; and therefore, how to meet the real health needs of our population.

This is a part of the final communique agreed to by all health and finance ministers in Moncton. The title of that document is significant. It is, "The Need for a Common Approach."

"The ministers of health and the ministers of finance of the provinces and territories, requested by their premiers, have met together to discuss the funding of health services in Canada. The special nature of this event shows how important this issue is in all parts of Canada.

We were all grappling with a common agenda: how to provide the most effective range of health services to our people; how to provide health services in the context of sound financial management; and how to respond to the changing societal, demographic and technological factors that are having such a profound impact on health care today; and therefore, how to meet the real health needs of our population.

Provincial health care plans cover every Canadian citizen, providing access to quality health care, regardless of individual financial circumstances. Canadians value these plans and are aware of the physical and financial security they provide. Canadians rightly consider them an essential component of the tradition of sharing, which is characteristic of our country.

For more than 30 years, the federal government and the provinces have been partners in establishing and maintaining public health care plans throughout the country. The provincial and territorial health and finance ministers look forward to meeting with their federal counterparts to discuss the continuation of a cooperative approach to funding health care services in Canada.

More specifically, the provincial and territorial health and finance ministers ask the federal government to at least index its established program financing contribution based on the growth of our collective wealth, that is, GNP.

For their part, the provinces and territories will continue to work together to find solutions to the challenge of maintaining and improving Canada's health care system."

Health and health care is not, nor should it be, a partisan issue. The issues facing us today are issues that cross all political divisions and all provincial boundaries. They are issues that no matter what our political affiliation or province, affect us all.

Health and health care is not, nor should it be, a partisan issue.

Our Canadian way of health care evolved as a national consensus and drew upon the talents and abilities of people from all walks of life and every political spectrum. They had courage, the vision and the wisdom to keep the public interest paramount.

That being said, we cannot forget that the development of our health care system stirred strong emotional responses and tremendous public discussion. At the same time, there were some people who simply did not agree with the principles of a publicly funded and publicly administered health care system.

Canadian health care was build on five guiding principles:

- Public administration by government;
- The portability of benefits from province to province;
- Accessibility to services without regard to economic or social circumstances;
- Universal coverage, meaning health care for everyone; and finally,

- Comprehensiveness, as broad a range of health care as possible to meet the needs of the Canadian people.

There are some who refused to help lay the foundations of our medicare system, just as there are some today who continue to try to undermine it. There are some who clamor for a "free market" medical system, who believe the answers to the challenges we face lie in user fees or a privately funded system.

I do not agree. Our health care system is a distinctly Canadian value. It is acknowledged as a model for the world, one that we must be ready to defend, protect and enhance. We can only do that if we recognize that we must prepare for change now. We must prepare our system to meet the changing and future needs of our people while at the same time defending those principles.

Our health care system is a distinctly Canadian value. It is acknowledged as a model for the world, one that we must be ready to defend, protect and enhance. We can only do that if we recognize that we must prepare for change now.

If we are to take seriously our responsibility to shape Canada's health care for the future, then we have a responsibility to, once again, find the political will and determination to make the decisions that must be made. That is our responsibility. We all have a role to play. We must be prepared to work cooperatively and to keep as our focus the health and well-being of every single Canadian.

Speaking for my own province, the Ontario government has honored and expanded upon those principles, and we have been proud to do so, and I am proud of our record and we are standing firmly and strongly on that record. In my home province no other government program, in either absolute or incremental terms, receives the kind of funding commitment that health care does. Health care now accounts for fully one-third of all the financial revenues available to our provincial treasury. Yet, even with our current provincial expenditure approaching 13 billion dollars, there are still some who say that 13 billion dollars is not enough. They argue for still more spending in the institutional sector.

In Ontario in the last five years, the per capita spending on health care, after inflation, went up 25 percent.

Dr. Michael Rachlis, co-author of the book *Second Opinion,* makes a very strong point when he says, "It is misleading to say that the problems with our health care system are due to lack of money. In Ontario in the last five years, the per capita spending on health care, after inflation, went up 25 percent. So one thing is crystal clear, that the answer to the problems we face in our health care system is simply not more money, we need to look at the way we organize our system."

I say, "Exactly." The facts of the matter are that many of the structures that served us well in the past are not serving us as well today, and they will be even less effective in the future. Our future lies in our willingness and our readiness to innovate, to create and to change.

The facts of the matter are that many of the structures that served us well in the past are not serving us as well today, and they will be even less effective in the future.

Everyone here knows quality of life, which we are so proud of in this country, means not just good health care. It means good education; it

means a clean environment; it means jobs; it means the right mix of social programs and social support networks; it means good roads; and it means a whole host of services that have a rightful claim to proper government funding. It means "healthy public policy."

We all agree that health is more than simply the treatment of illness. Health services must receive their fair share of revenues, but so must the other services and programs which we have a responsibility and an obligation to finance and to support if we are to have a "truly" healthy society.

In response to the economic, demographic and technological imperatives for change, we must now create the positive shifts and the re-alignments within health care that will enable us to meet current needs, and equally important, to prepare for the future, to meet the real and the changing needs of our people.

One positive shift, and the focus of this conference, is the renewed emphasis on health promotion and disease prevention. Simply treating illness is not enough; we must go to the source of the illness. We must, therefore, empower people to take much responsibility for their own health.

Simply treating illness is not enough; we must go to the source of the illness.

We know that many of the diseases for which people now seek treatment - diseases such as cancer, heart and lung disease, cirrhosis - often have strong environmental and lifestyle connections. That means we must be able to provide people with the options, the alternatives and the information to make that good personal health choice both practical and possible.

Twenty years ago, when we spoke about health, we were usually speaking about the illness treatment system, about doctors, about nurses and about operating rooms. Our dependency on treatment has resulted in the highest rate of institutionalization in the western world. Today, we understand more clearly the direct relationship between our own health and the choices and the decision that we make, both individually and collectively.

Health is not just the absence of disease but a positive resource for living.

We understand that health is not just the absence of disease but a positive resource for living, and as individuals, we must take greater responsibility to protect that resource. We must empower people through public education and information to enable them to make healthy choices and live life to the fullest with dignity and with independence.

In addition to providing the full range of treatment services, our health care system has a responsibility to help people stay well, to help people protect and maintain their own health.

In addition to providing the full range of treatment services, our health care system has a responsibility to help people stay well, to help people protect and maintain their own health. To accomplish this, we are encouraging a positive shift towards greater quality assurance and out-come review in patient care. That means we must know what is effective and what is not, and in order to know, we have to have more clearly defined and agreed upon standards for the appropriate and effective use of our resources.

There is evidence, from a number of studies, both here in Canada and in the United States, that at least some of our precious health care resources are being spent on programs and procedures that are, at best, achieving questionable results. It's my view that new emphasis on quality assurance and accountability will be one of the key factors leading to a healthier future. I also believe that quality assurance is destined to play a major role in determining not only the future shape of health care, but also health care funding patterns as well. Premier Peterson and I are delighted to be hosting the National Symposium on Quality Assurance to be held later this year.

As we help lay the groundwork for the strategic management and program planning of health care, let us never forget the basic principles upon which our Canadian health care system is built: universality, accessibility and comprehensiveness. Let us remember, too, the financial, technological and demographic pressures facing health care, and how our understanding of health is changing with its new emphasis on health promotion and disease prevention. Our leadership role, in the public interest, demands that we ask for quality assurance and accountability.

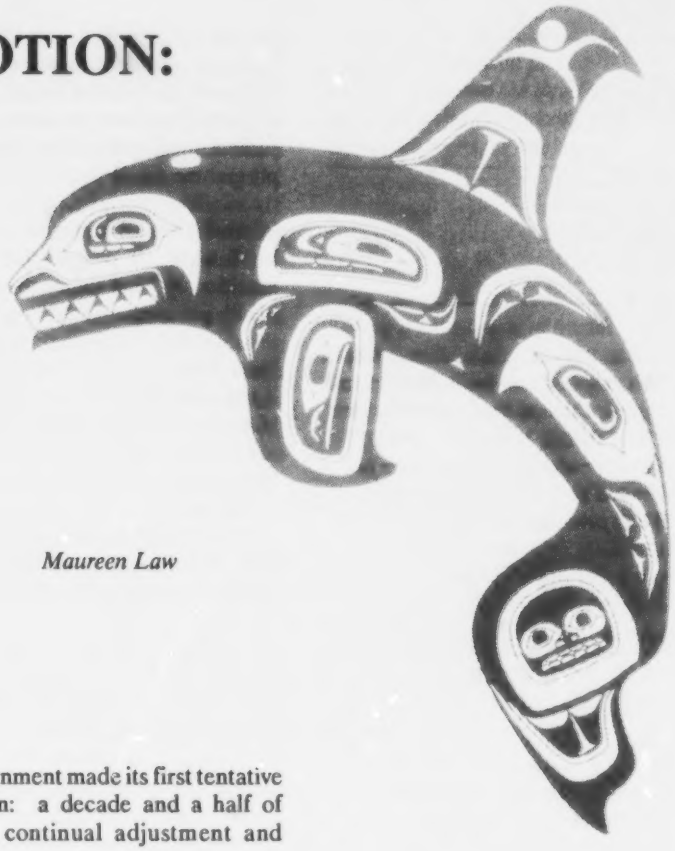
Our leadership role, in the public interest, demands that we ask for quality assurance and accountability.

Let us look to new, positive shifts to community-based services as a means of providing effective quality care, as close to home as possible.

Let us give the people the opportunity to be well, through knowledge. This is the vision of every Canadian, the vision that I fully expect will lead this country towards a safe, confident and healthier future.

HEALTH PROMOTION: A DYNAMIC FOR CHANGE

Maureen Law



FEDERAL REPORT

It is now about 15 years since the federal government made its first tentative moves in the direction of health promotion: a decade and a half of on-the-job learning, remarkable growth, continual adjustment and abundant returns for our efforts.

Today Canada plays a confident role in the world forum as an enthusiastic supporter and proponent of health promotion. This we can do because the experience and knowledge we have gained indicates clearly that we are on the right track and that our expectations concerning the role of health promotion in Canada's future health system are well grounded, realistic and supported by the evidence. We have high hopes, and I want to tell you why.

Today Canada plays a confident role in the world forum as an enthusiastic supporter and proponent of health promotion.

Until the release *A New Perspective on the Health of Canadians*, Canada's approach to health was based almost entirely on a disease model. Health was something that resulted from the prevention or treatment of illness.

As you know, the 1974 document took a somewhat different view. The release of this publication added momentum to a new trend, that of promoting healthy lifestyles, and when the federal government established the Health Promotion Directorate in 1978, its organization reflected this.

The goal of health promotion was to alter those lifestyles which, it was believed, gave rise to health problems like heart disease, stroke, accidents and hypertension. As we then saw it, our task was to persuade people to reduce their risk-taking behavior and thus their chances of illness and premature death.

In crude terms, the message of the day was one of individual responsibility for health. If people did not smoke, if they drank moderately, ate nutritiously, kept themselves physically fit and used contraceptives, their health prospects would improve.

This emphasis on individual lifestyle change, important though it was, tended to eclipse some of the other very significant ideas put forward in A New Perspective. While personal choice was obviously an important factor, it was becoming clear that environmental conditions were at least as influential, if not more so.

For a while, this emphasis on individual lifestyle change, important though it was, tended to eclipse some of the other very significant ideas put forward in *A New Perspective.*

In the early '80s, this imbalance began to be redressed. Increasingly, people in the health field were questioning the validity of making individuals completely responsible for their own health. While personal choice was obviously an important factor, it was becoming clear that environmental conditions were at least as influential, if not more so.

Such things as economic and sexual inequality, pollutants and occupational hazards were all recognized as contributors to ill health. Although these were conditions that lay mainly outside the control of individuals and groups, their ability to undermine health was patent.

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A new vision of health began to emerge: a vision that took more explicit account of the links between health and the social and physical environment. There was a movement away from the tendency to let the individual shoulder the blame - thus doubly victimizing him or her - toward the adoption of a more ecological view of health. Clearly no care system, however efficient, could be adequate to ensure the full development of this concept of health.

When my department released *Achieving Health for All: A Framework for Health Promotion* at the end of 1986, it marked the culmination of a long process of rethinking, involving a considerable cross-pollination of ideas between Canada and the WHO's regional office for Europe. The Canadian framework endorsed the notion of health proposed by the WHO as a positive resource, rather than as something resulting merely from the prevention or treatment of illness. By extension, the goal of health promotion was to enable people to increase control over and to improve their health.

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Gaining more control, the process of empowerment, suggests the creation of new relationships and the redistribution of power. It also implies community development and social action. The framework reflects this conceptual shift, as well as illustrating the dynamic nature of health

promotion. For example, it calls for increased public participation and the development of public policies marked by an explicit concern for health.

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If our home, schools, workplace and community environments, both social and physical, have a fundamental effect on our health prospects, it follows that the health department alone cannot be responsible for setting the necessary policies. Agriculture, waste management and energy policies are also critical. So, too are our child care, income distribution and education policies.

Taking a broad view of health requires radical adjustments at the institutional level and in our policy-making processes. It involves crossing traditional departmental boundaries. It calls for genuine dialogue between decision-makers and the various "publics" toward whom the policies are aimed. Above all, it requires co-ordination. In Canada, this means working co-operatively with other departments, with three levels of government and with the non-governmental and private sectors. It is a tall order.

Taking a broad view of health requires radical adjustments at the institutional level and in our policy-making processes.

The good news is that we are doing it and that it's working. In the last two or three years, we have travelled a considerable distance together. Inch by inch, we are creating infrastructures that work in support of healthy public policy development instead of against it.

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Take the national drug strategy, "Action on Drug Abuse," as an example. As most of you know, the development of this strategy came out of a truly collaborative process which involved many federal government departments: Fitness and Amateur Sport; the Solicitor General; the Ministry of Justice; the RCMP; the Ministry Responsible for Youth; the Departments of External Affairs, Customs and Excise; Indian Affairs and Northern Development; Transport; National Defense; and last, but not least, of course, Health and Welfare.

All provincial and territorial governments were involved. Moreover, public input was invited in a series of cross-country consultations. We sought views on the problems and their solutions from everyone concerned, including community groups, parents and young Canadians from coast to coast.

There are other examples: the national program to reduce tobacco use; the collaborative Heart Health Program, and the long-term national program to reduce impaired driving. And now there are encouraging signs that the creation of a national coalition for school health is not far off.

In the course of this rather cumbersome, sometimes even painful, process of collaboration, there are a number of benefits. Many are quite separate from the officially listed program objectives. They include improved communication among key sectors and interest groups, a more efficient exchange of current information and the emergence of strong, vibrant networks.

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We have other reasons to be encouraged. A Canadian consulting firm has just carried out an independent evaluation of our health promotion program. I will not go so far as to say that this study heaps praise upon us, but I have every reason to be more than happy with the results. The evaluation gives tangible evidence that appreciable progress has been made in Canada. Our efforts are beginning to bear fruit.

The evaluation report states that the influence of the health promotion program is significant in terms of:

- Improved strategies and planning;
- Increased research;
- Creating public awareness about health promotion issues, and
- Improved intersectoral co-ordination.

We also learned that more had been accomplished in the area of promoting awareness than in achieving behavioral change, and this is, of course, what we all need to work on.

Some of the best news to come out of the evaluation was that our Health Promotion Contribution Program is effective and highly regarded. This program encourages voluntary action on health issues. For eight years, it has provided funds in support of community based projects that enable Canadians to maintain or improve their health. We at Health and Welfare have found this to be an excellent way of demonstrating our commitment to public participation. Communities identify their own problems, suggest how to solve them and take responsibility for doing so. The federal role is to facilitate this process.

Key informants and expert groups across the country have confirmed what we have always felt, that the federal Health Promotion Program has made a difference. The evaluation findings have reassured us that we stand on solid ground. Moreover, they give us clear direction in recommending a strong national leadership role for the federal government and in indicating what our priorities should be in the years to come.

Suddenly, the year 2000 seems very close. We have a mere ten years left. That we are on track is encouraging, but there are still many promises to keep and miles to go before we sleep.

Our own experience and knowledge, combined with the opinions of experts have helped us chart a path which builds on strengths and continues to use health promotion as a dynamic force for change. This route will see us continuing our commitment to communities and public participation, extending our efforts to develop and coordinate partnerships with many

sectors, increasingly attending to the need to develop a firm knowledge base for health promotion, and finally, taking up the serious health issues of our time that require national attention.

Strengthening community health, the second framework strategy, is one of our highest priorities, because it is at the community level that health promotion can truly thrive and have its most enduring impacts. Here again, my department sees itself largely as a facilitator. I have already mentioned our Health Promotion Contribution Program. It continues strong and we will expand it.

My department is also providing $3 million over the next three years to the Canadian Public Health Association for a new initiative aimed at strengthening community health. Following the release of *Achieving Health for All,* the CPHA used its network of branches and associations in all regions of the country to organize ten provincial/territorial workshops. The objective was to obtain a clearer picture of the issues, needs and gaps in community health as locally perceived.

The report from that consultation, entitled *Strengthening Community Health Means Strengthening Communities,* proposes a wide-ranging agenda for action involving many different sectors, all levels of government, health-related and other organizations, and of course, communities themselves.

To help implement the recommendations of this report, we have provided financial support to CPHA to set up a Community Health Secretariat within its Ottawa office. The new secretariat will provide national leadership in strengthening the health of Canadian communities through a variety of initiatives. Already, multi-sectoral groups are meeting in every province and territory with a view to working out their own individual action plans for strengthening community health.

Health and Welfare has also thrown its support behind another imaginative enterprise, the "Canadian Healthy Communities Project," whose counterpart, the "Healthy Cities Project," thrives in many European communities.

The Canadian project is aimed at creating healthier environments for the 80 percent of our citizens who live in urban settings. Municipal policies and programs are the target. The healthy community concept encourages municipalities to weigh the health implications of their actions at every stage of policy planning and formation. It calls for them to work cooperatively with the private and voluntary sectors to create communities where the healthy choices are the easy ones. Central to this concept is the improvement of the physical and social environments. So, too, is the ready availability of community resources that enable residents to be mutually supportive and to develop to their full potential.

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The Canadian Healthy Communities Project is co-sponsored by the Canadian Institute of Planners, the Federation of Canadian Municipalities and the Canadian Public Health Association. My department has contributed by funding the establishment of a national "Healthy Communities Office" located in the Canadian Urban Planners' Ottawa headquarters.

More and more communities are showing an interest in taking part, and the role of this new office is to help them to develop and evaluate appropriate multi-sectoral policies and working models of community-level health promotion. It also distributes resources to participating communities, publishes a monthly newsletter entitled *Challenge,* and documents and analyzes various local-level activities.

We also plan to increase our efforts in the area of intersectoral cooperation. I have already spoken of national initiatives in the use of tobacco and in other areas. The models and processes developed will be progressively refined and used wherever they apply. We are particularly proud of our new collaborative partnership with the Department of the Environment. Mr. Beatty has recently been appointed deputy chairperson of a new Cabinet Committee on the Environment. This places health squarely on the agenda when environmental policy and decisions are made.

We urgently need to flesh out the concepts contained in the health promotion framework. This means embarking on a systematic program of research into the challenges, the mechanisms, the strategies, and the interrelationships among them.

A great deal of work lies before us in another area, that of knowledge development. We urgently need to flesh out the concepts contained in the health promotion framework. This means embarking on a systematic program of research into the challenges, the mechanisms, the strategies, and the interrelationships among them.

One of our most important literature reviews is *Co-ordinating Healthy Public Policy,* written by a team from the University of Toronto, which provides clear documented insights into what healthy public policy means in the Canadian context.

The process of establishing research priorities is quite well advanced. Last year, the department commissioned a series of literature reviews and papers on the elements of the health promotion framework, following this up with community-level consultations across the county. Workshops have now been held in every region of Canada involving academics, health personnel, community activists, and the representatives of a range of disciplines and interests from outside the health field.

Later this year, Health and Welfare will release a national report containing the results of this participatory process, and the National Health Research Development Program will solicit and fund appropriate health promotion and research proposals. These we expect to come from researchers working in many different disciplines.

We intend to place more emphasis on certain health issues, including mental health and nutrition. Many of you will be aware of the federal discussion paper, *Mental Health for Canadians: Striking a Balance,* which we released in the fall of 1988. We are currently engaged in a series of follow-up consultations across Canada to sound out public reaction and to help set policy and program directions in the area of mental health.

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Nutrition may seem like an old issue. However, new challenges continue to emerge in this area, as Canadians respond to the complex and diverse factors which affect their choice of foods and lifestyle. A priority for Health and Welfare is to set out revised nutrition recommendations for Canadians. These will serve as dietary guidelines and, with recommended strategies, will establish a framework for nutrition programs and policies.

At the same time, we are dealing with widespread concern in Canada on the subject of weight problems. The challenges range from obesity and overweight to anorexia nervosa and bulimia. My department recently released a discussion paper entitled *Promoting Healthy Weights*, along with a technical document, *Canadian Guidelines for Health Weights.* We are now working with Fitness Canada to introduce an integrated approach to body weight which will emphasize healthy eating, enjoyable physical activity and a positive body image.

I hope I have been able to demonstrate the depth of the federal commitment to the concepts and practice of health promotion and why we have such high hopes that health promotion will take its proper place alongside health care as a cornerstone of Canada's system for health.

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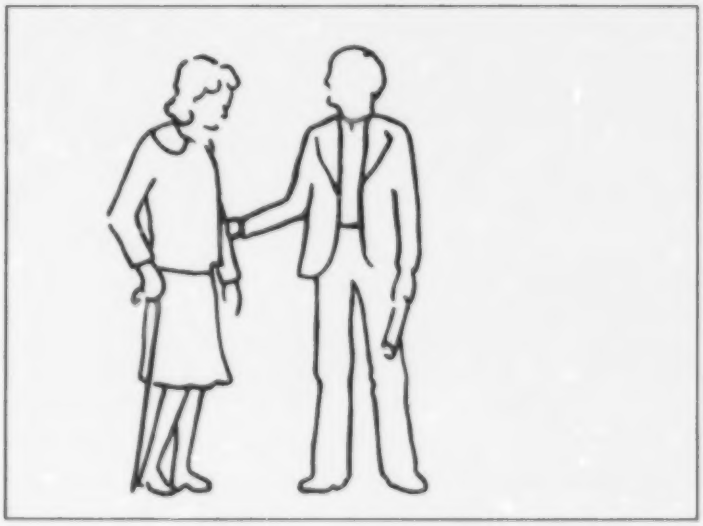
Today we are facing some situations which have no historical precedent. The worldwide AIDS epidemic is a particularly frightening example. It poses a multitude of problems for communities, health professionals and government. We need new structures and a new way of thinking.

We must increase our prevention efforts as well as support our mutual aid activities. Our community health services must be reinforced if we hope to deal with this crisis effectively.

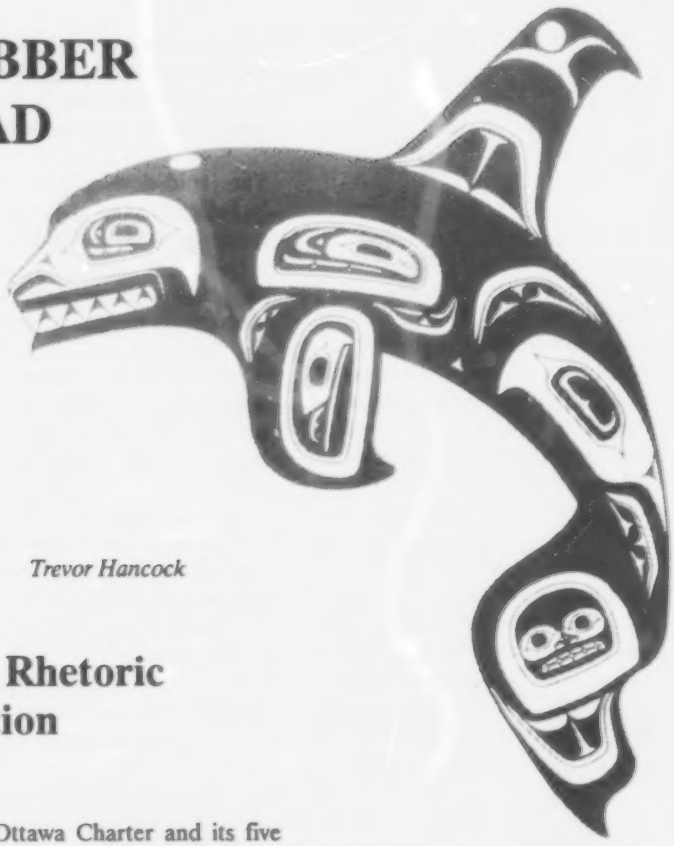
Like so many people who work in health promotion, I have developed a passionate commitment to making the vision a reality. I am, you might say, a true believer. But this is more than blind faith. I am also trained in science, and I am most comfortable when the evidence is before me. Happily, it is accumulating quickly, so I have no hesitation in preaching the message.

We began with a vision. Now we have added experience and knowledge. We have always had energy and will. What remains now is an obligation, and the obligation is to make it all work.

ACTIONS



WHERE THE RUBBER MEETS THE ROAD



Trevor Hancock

From Health Promotion Rhetoric to Health Promotion Action

Let me start by reminding you about the Ottawa Charter and its five strategies and its companion, the federal document, *Achieving Health for All: A Framework for Health Promotion*. Although *Achieving Health for All* used nine boxes, it was really talking about the Charter's five strategies. It's worth keeping those two documents in mind. They are fundamental.

The federal framework added one thing for which we should be grateful: the concern with inequities. Both documents use the same definition of health promotion. It is the process of enabling people to increase control over and to improve their health. That process of increasing control is fundamental to what we are talking about.

In the intervening two and one-half years since the Ottawa conference at which both those documents were released, health promotion has moved swiftly to occupy a central place on the health agenda. What we heard in presentations about healthy public policy committees in Manitoba and Ontario is quite remarkable.

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If you'd asked me in 1984 when we did Beyond Health Care, what chance there was that the notion of healthy public policy would begin to be expressed in governmental structures within four of five years, I wouldn't have given you a plugged nickel for its chances.

expressed in governmental structures within four of five years, I wouldn't have given you a plugged nickel for its chances. It's impressive that health promotion is moving swiftly to the center. However, in some ways, that swiftness has been part of the problem.

The rapid development has brought with it some problems of success, including the fact that we have not had time to establish a broad base of understanding of what health promotion is all about.

A second problem has been that we do not have adequate resources. The idea has grown quicker than the resources to support it.

A third problem is that we have few models of success. Equally important, we haven't had enough time to make mistakes and learn from them, particularly the community groups. And making mistakes is very important. We have to do it. It's painful, but it has to be done.

Finally, health promotion, in spite of its recent rapid success, is, in fact, a long-term process. Nancy Milio, who is one of the key people in thinking and talking about healthy public policy and health promotion, describes it as a long-term social learning enterprise. I agree with her, and that means it's going to take us not a couple of years but five, ten, fifteen, twenty or more years.

These problems of success form some of the backdrop to my thinking about what we need in order to move health promotion from rhetoric into action.

I'm going to talk about five themes. They are: first, the need for understanding and recognition of what health promotion is about and what its implications are, and the need to build an infrastructure and a capacity for health promotion; and then three strategies which I think are key - development of healthy public policy, the strengthening of community action and the development of personal skills.

Understanding and Recognition

Health promotion is not a new, wild, or radical idea.

Health promotion is not a new, wild, or radical idea. The notion of healthy public policy is not new either. You can go back to Johann Peter Frank in the latter part of the 18th century and find ideas there that are not radically different from what we are talking about.

The idea of healthy public policy challenges the assumption which has prevailed for the past 50 years that health is the result of health care services.

Although there is nothing inherently new about the role of public policy in making health possible, the idea of healthy public policy challenges the assumption which has prevailed for the past 50 years that health is the result of health care services.

From here on I will call them sick care services, because that's what they really are. These services are very important. When I'm sick, I want good sick care services.

The first part of understanding what health promotion is all about is understanding the limits to sick care. As good as our sick care service system is, it's not enough. Recognizing and accepting that will not be easy, but it is vitally necessary.

Understanding health promotion means facing the fact that there are limits to our sick care system and to the ideology that underlies it. To my mind, those limits are threefold: biological limits in that we cannot, in the long run, conquer death but only postpone it, and we cannot easily repair the ravages of poverty and poor environment with biomedical interventions. There are also financial limits in that there will never be enough money to do all the things that we could do, and ethical limits in that even if there were enough money to do all the things we could do, should we do them?

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These are not easy questions, and they are not the province of health professions alone or of politicians alone. That means we as a society must have a wide public discussion about the limits to the medical system - the limits to sick care, as I would put it.

Governments have to commit themselves to initiating that public discussion. One model they may like to look at is in the state of Victoria in Australia where something called a Health Issue Center has been funded by government. The purpose of that center is to raise these issues, to initiate that public debate. I think we could do with a health issues center in each province across the country.

My second point, in terms of understanding and recognition, is that we need health goals. They are an important symbol.

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Health goals have been proposed already in Quebec as *objectif sante;* they have been proposed in Ontario, and most recently they are being proposed in British Columbia. The problem is not with proposing them, it's that in none of those jurisdictions have they yet been adopted. It's time we adopted some health goals, We have to start provincially. Ultimately, we need national health goals, but the process the Canadian Public Health Association proposed several years ago consisting of a series of provincial and regional processes leading to provincial and regional goals and then moving on to national health goals is the way to go. I also like the proposal in the Spasoff Committee report which suggested setting broad national goals and establishing specific objectives at the local level.

Setting goals is an important part, too, of recognition and understanding. In order to create recognition and understanding, we have to be advocates for health. In particular, ministries of health have to initiate the same public discussion as they are having within governments, and become advocates for health.

Infrastructure and Capacity

After we have established understanding and recognition, we need to underpin that shift in understanding by building the infrastructure and the capacity to do health promotion. This is absolutely fundamental. Without this, we cannot do health promotion.

In this connection, I'm going to talk about five areas: funding; defining roles - who should be doing health promotion; knowledge development; education and training; and the need for national centers of excellence.

The first thing we have to do is to recognize that public health, and with it much of health promotion, does not come under the *Canada Health Act.* We would more accurately describe it, in fact, as the "Canada Medical Procedures Insurance Act." And that, to say the least, is a curious anomaly. It is high time that health promotion and public health was cost shared. It would be even better if the federal and provincial governments could sit down and agree upon a real Canada Health Act.

It is high time that health promotion and public health was cost shared. It would be even better if the federal and provincial governments could sit down and agree upon a real Canada Health Act.

You have heard a great deal about the fact that the present level of funding for health promotion and public health is inadequate. Estimates consistently suggest that somewhere around two to three percent of health budgets are spent on health promotion and public health.

We can get new funds in one of two ways: either put new funds in or reallocate existing funds. I will argue on both sides of that question, because there are pros and cons to both approaches.

It might be argued that the health budget is already quite large enough. I'm sure that those health ministers who are having to argue with their treasurers about spending a third of the provincial budget on health are constantly getting the argument back, "You're getting enough."

I'm sure that those health ministers who are having to argue with their treasurers about spending a third of the provincial budget on health are constantly getting the argument back, "You're getting enough."

I tend to agree with that, particularly when the funds might be made available to other sectors where they might create greater health benefit: for example, in improving social assistance levels or in maintaining safe highways or in providing universal day-care.

There is a strong argument to be made that the health budget already has a big enough share of total budgets. On the other hand, there is nothing magic about a particular level of spending for health. If society believes that health is a priority and that spending on health and its prerequisites is an important social investment, then why not spend 10 or 11 or 12 or 13 percent of GNP, or whatever it may be, on health?

The argument about allocating new funds to health promotion can go both ways. On the other hand, there are strong arguments - perhaps stronger arguments - for reallocating resources within the existing health budget.

To continue to find new funds for our existing system merely perpetuates an inefficient system. A commitment to shift half of one percent of the health budget annually for five years from the treatment to the health promotion sector would create strong pressures for more efficient use of existing dollars. This could usefully be accompanied by a commitment to refuse to fund new treatment programs that include a health promotion or disease prevention component.

A commitment to shift half of one percent of the health budget annually for five years from the treatment to the health promotion sector would create strong pressures for more efficient use of existing dollars.

I would like to qualify that by saying that I don't think the health promotion or disease prevention component to new treatment programs should be provided by the hospital or by whoever proposes the treatment program. It should be provided by a community group in conjunction with the hospital, with funding going to the community group. That would make hospitals start to work with community groups, and it would benefit the community groups by funding them.

Half of one percent is not a big share of the health budget to reallocate in one year. Over a five-year period, however, it virtually doubles the resources we have for public health and health promotion, and it does so in a slow, planned way that enables us to phase it in and plan for it and work with it.

At the same time, on the topic of funding, we must avoid falling into the trap of seeing health promotion simply as a way of cutting costs. I'm not sure that health promotion will cut costs, and I don't think that's the reason we should be doing it anyway. We should be doing health promotion because it improves people's quality of life, and it's a good thing to be doing.

If governments want to save costs, they could save a lot more money lot quicker by making the existing inefficient system efficient. That's where the cost savings are to be found. You channel some of those cost savings into supporting health promotion and possibly you channel some of those savings completely out of the health sector into houses and roads and income support and whatever else it may be - literacy - that makes it possible for people to be healthy.

The allocation or reallocation of funds for health promotion and disease prevention will have to be accompanied by a definition of roles. Hospital are moving into the health promotion sector, and in my view, that is a problem. There are three reasons why hospitals are not the obvious place to do health promotion. Hospitals institutionalize, hospitals medicalize, and hospitals individualize. They should. That's their role and that's the way they're set up, and it's not surprising that they would do those things.

There are three reasons why hospitals are not the obvious place to do health promotion. Hospitals institutionalize, hospitals medicalize, and hospitals individualize.

However, that is anathema to much of health promotion, which is about deinstitutionalization. To put it in a more positive sense, it's about community, it's about a health model, and it's about a collective as opposed to an individual approach. Hospitals, as a general rule, should not be

involved in health promotion, at least health promotion as we are talking about it here. I would concede that there are good arguments, particularly in smaller communities, for having hospitals involved in health promotion; but we need our general rule first, and then we find out where the exceptions lie.

I would like hospitals, instead, to focus on being good at diagnosing, treating and caring for illness. I don't think that we do that as well as we should, and we certainly don't do it as efficiently as we should. That is where their efforts should be.

I would make a similar argument about the role of physicians. On the whole, they should not be primarily in the business of health promotion, for two reasons. One is their training, which is not a training that equips them for health promotion, and secondly, because they're the most expensive deliverers of service.

I would make a similar argument about the role of physicians. On the whole, they should not be primarily in the business of health promotion, for two reasons. One is their training, which is not a training that equips them for health promotion, and secondly, because they're the most expensive deliverers of service.

Where hospitals and physicians do have a role is in some primary prevention and certainly quite a lot of secondary prevention - clinical prevention. I have no arguments with that at all, but we are going to have to define roles, and in defining roles we are going to have to address these two tough issues. You can't walk around them or run away from them.

I want to move on from there to talk about knowledge development for health promotion. In a recent article, Irving Rubeman said Health and Welfare Canada takes the view that the development of knowledge concerning the ideas in the health promotion framework should be accorded high priority in order to give shape and focus to health promotion and to facilitate the use of the framework.

By knowledge development he meant two things: he meant knowledge dissemination - the sharing of existing knowledge - and research. There are several things we need to do in the area of health promotion research.

We need to legitimize and support new research approaches: community research, action research. We need to legitimize and support multi-disciplinary approaches to health promotion research. We need to expand the network of researchers. We need to strengthen the links between researchers and the community. We need to strengthen the infrastructure for health promotion research.

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We have an important knowledge development agenda, including both dissemination and research, and I would make a particular plea for dedicated health promotion research funds - autonomous dedicated funds. One proposal that came out of a recent workshop on research in Toronto was to look at something akin to the Ontario Mental Health Foundation, which is funded but is autonomous and develops its own funding. In any case, whatever the model is, we need dedicated research dollars. We also need from NHRDP a strategic grants program that includes career

development awards, fellowships and standards of excellence, specifically for health promotion research.

We need dedicated research dollars. We also need from NHRDP a strategic grants program that includes career development awards, fellowships and standards of excellence, specifically for health promotion research.

Knowledge development is the third part of building a health promotion infrastructure and capacity. The fourth is education and training for health promotion. In this area we need several things. We need to support new programs at the undergraduate level that are multi-disciplinary in nature and that focus on community development approaches in particular. Both can be expansions of existing programs so that we develop health promotion education within non-health sectors.

I have in mind at Ryerson an interdisciplinary program in health promotion which is offered to students in nursing, environmental health, social work, early childhood education, urban and regional planning, and food and nutrition and consumer studies. Students from all six of those schools are taking a minor in health promotion. That's the sort of thing we need to look at, in addition to whole new programs to train people in health promotion, particularly with a focus on the community development approach.

In addition to undergraduate training, we obviously need graduate training, particularly for the knowledge development strategy and the management of health promotion programs. But equally, if not more important, we need continuing education to ensure that existing health practitioners, particularly in the public health field, are adequately trained in the new skills and knowledge of health promotion.

We need continuing education to ensure that existing health practitioners, particularly in the public health field, are adequately trained in the new skills and knowledge of health promotion.

We are also going to need summer school programs like the Alberta Summer School in Edmonton. These would be certificate and diploma programs, retraining programs, to help people make the transition from the old public health to the new public health. Many people are making that transition, but they are doing it without the sort of support they need and deserve.

We need education at the community level, education for people who are not health professionals but who are interested in health and health promotion. We need to give them the skills necessary to participate actively in personal and community action for health.

Finally, we need national centers, or one national center of excellence for health promotion. The research, education and training agendas that are fundamental to health promotion would probably be best served by the establishment of one or more national centers.

The research, education and training agendas that are fundamental to health promotion would probably be best served by the establishment of one or more national centers.

I would like to quote Milton Terris in talking about, first of all, a school of public health. "A school of public health," he said, "clearly excludes departments of preventive, social or community medicine, which are part of and subordinate to medical schools. A school of public health is, by definition, an independent graduate school. Schools of public health educate individuals to become members of the public health profession - a

group which is quite distinct from medical, nursing, and health practitioners educated in their own professional schools."

This view has been supported recently by two strong editorials by John Last in the *Canadian Journal of Public Health*. In his view, insofar as centers of all-round excellence in public health can be identified in the world, we have none at all in Canada.

That is a challenging and upsetting statement. And John Last concurs with Milton Terris that: "Public health is too important to be left to deans of medical schools. No matter how sincerely deans may promise to preserve and strengthen basic and applied science departments, experience has repeatedly shown that when budgets are tight, these aspects of medical school activity are extremely vulnerable."

Terris went on to call for a national center or a network of centers of excellence for the new public health. There is no question in my mind that we need those centers, and that means joint federal and provincial action to establish them.

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Next I want to talk briefly about healthy public policy, about strengthening community action, and about developing personal skills.

Healthy Public Policy

Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. Equity is fundamental to healthy public policy, and we have started to see the development of healthy policy models not just at the government level but also at the local level. "Healthy Cities," for example, is a way of encouraging healthy public policy at the local level, and equity has to be an important part of what they address.

Equity is fundamental to healthy public policy.

There are three issues that are crucial to a discussion of healthy public policy. The first is the issue of health inequalities and social inequities. The Adelaide statement said that inequalities in health are rooted in inequities in society. Closing the health gap between the socially and educationally disadvantaged and the more advantaged in society necessitates a policy that improves access to health enhancing goods and services and creates supportive environments.

That means we have to address hunger, homelessness, unemployment, poverty and illiteracy if we are to improve the health of those whose health is worse. This particularly applies to the poor health of native Canadians.

This important fact has been recognized by the Social Assistance Review Committee in Ontario who, in a very important comment in their report, said that: "Many of the recommendations in this report are intended to improve the general financial position of social assistance recipients and

the working poor. Their adoption may be the most important health measures that Ontario could introduce."

I agree entirely. To the extent that increased funding of the sick care system reduces the possibility of finding funds to implement the recommendations of the Social Assistance Review Committee, the current campaign we're seeing by the hospitals and the medical profession to increase hospital funding may, in fact, prove to be profoundly harmful to health. We need to say that, and say it loud and clear.

That means we have to address hunger, homelessness, unemployment, poverty and illiteracy if we are to improve the health of those whose health is worse. This particularly applies to the poor health of native Canadians.

Sustainable development and healthy environments is a second area of healthy public policy where there are wonderful opportunities. About a year ago, the First Ministers established round tables on environment and economy. In addition, Health and Welfare Canada and Environment Canada are working together on a conference that we are organizing at York University called, "Health, Environment and Economy."

We are beginning to look at the links between these three areas, and there is an important window of opportunity here for us to bring together the health and environment fields. Don't forget that environment is at the top of everybody's agenda these days, and what is equally important is that the people who are working on environmental issues are recognizing that one of the most important ways to sell them is in terms of their health impact.

We have to bring health and environment closely together. The Healthy Communities Project provides another important opportunity to do that at the local level, and local action is terribly important.

The third area of healthy public policy concerns food and agricultural policy. This is a very important area where there are already examples: the state of Victoria in Australia; Norway; and at the local level in Knoxville, Tennessee, where a Food Policy Council has been set up. There are already examples of trying to reorganize food and agriculture policy to produce a healthy diet.

We have to bring health and environment closely together.

However, healthy public policy also needs structures and processes. We need multisectoral structures for healthy public policy at the national level and at the provincial level. One example is the Ontario Premier's Council. I was not aware until recently of the proposal in Manitoba, but that's another example, and there may be others I am not aware of.

We need multisectoral structures at the local level, too, but the Healthy Communities Project requires communities to establish multisectoral committees. We also need a set of strategies for healthy public policy. We need to research what is already going on in the field of healthy public policy. We need to spread the word and we need to find new partners. We need to establish some proof of concept projects - an idea I've taken from South Australia, where they have set out to establish proof of concept

projects in healthy public policy. Let's take a couple of areas and try them and see what happens.

Strengthening Community Action

"Strengthen Community Action" is the title of the report that the CPHA produced out of their series of consultations across the country in 1987. The realization that strengthening community health means strengthening community is a very important concept and one we should keep in the fronts of our minds.

There are three parts to strengthening community action. The first part is to strengthen the community health sector. That is a little different from what I was talking about earlier when I talked about funding going to health promotion and public health. Here I'm talking about shifting funding from the institution-based provision of sick care services to the community-based provision of sick care services. We need to shift resources, and we also need to decentralize the management and control of the health care system in order to strengthen the community health sector.

I don't think we can move swiftly to the sort of model you find in the Nordic countries, and I wouldn't advocate something as extensive as that. They have a very different social and political history. But it is instructive to learn that in Finland, which has a population of 4 million people, the Health Directorate within the Ministry of Social Affairs consists of only 15 staff, including secretarial support. The National Board of Health in Finland, which is responsible both for national health planning and for regulation of the health professions, has a staff of only 200. The rest of their system is decentralized.

The National Board of Health in Finland, which is responsible both for national health planning and for regulation of the health professions, has a staff of only 200. The rest of their system is decentralized.

I'm not saying we can get to that point in one easy step, but at least it gives us an indication. Their system is not only not falling apart, but it's one of the best systems you'll find anywhere.

We have to look seriously at decentralizing power and control over the health care system to the local level. It's time that at least one government in this country gave funding authority to locally accountable bodies operating within central government parameters and frameworks. Central government has to set the standards, the frameworks and within that, give local bodies the money and ask them to figure out how they will do it. I think several alternative systems should be set up, as a start.

Another important point about strengthening the community health sector will be to facilitate bringing together the many fragmented parts of that sector in order to provide a strong and unified voice. There is an interesting model in Australia where the commonwealth government funded something called the Consumer's Health Forum. It brings together 16 or 17 community-based health groups to provide a counterbalance to the strong hospital and medical associations.

The instructions that now go out to the commonwealth bureaucracy say, "You will take into account the views of the hospital sector, the medical sector and the consumer's health forum." They have created a voice which was not there before, bringing together the many different fragments of the community sector. That is something governments in this country could look to.

There is an interesting model in Australia where the commonwealth government funded something called the Consumer's Health Forum. It brings together 16 or 17 community-based health groups to provide a counterbalance to the strong hospital and medical associations.

The second part of strengthening community action is the need to strengthen community control. If it makes sense to decentralize management and control over the sick care system, then it makes sense to do it everywhere. This is what is meant by public participation. Public participation is not merely the ability to turn up and vote once in a while; it's to be actively involved in managing one's local circumstances.

What I am calling for is a process of empowerment of both individuals and communities, the fostering of public participation and the enhancement of citizenship skills. Surely we are all agreed that enhancing democratic participation and citizenship is beneficial. If it is also good for health, who could possibly object?

Public participation is not merely the ability to turn up and vote once in a while; it's to be actively involved in managing one's local circumstances.

Finally, in terms of strengthening community action, we have to strengthen the community support sector. We need to look at both self-help groups - the community health groups that are concerned with addressing social, environmental and other issues that affect health and well-being - and community development health projects in which paid community health workers operate at the neighborhood level to assist residents to identify their health needs and interests and to organize themselves collectively to attempt to get those needs met. The strengthening of both formal and, more importantly, community support systems is a key strategy.

To close out this section I would like to refer to a wonderful comment by John McKnight, an experienced and thoughtful community worker in Chicago who said, "It is impossible to produce health among the powerless. It is impossible to allow health by transferring tools, authority, budgets and income to those with the malady of powerlessness." There are many people in our society who have that malady of powerlessness; they will not be made better by giving them medical services.

I want to make a brief reference to the Healthy Communities Project. The purpose of that project, which is based at the Canadian Institute of Planners and co-sponsored by the Federation of Canadian Municipalities and the Canadian Public Health Association, is to develop, at the local level, healthy public policy, environments for health and community action, and new partners for health.

"It is impossible to produce health among the powerless. It is impossible to allow health by transferring tools, authority, budgets and income to those with the malady of powerlessness."

One of the most useful things that provincial governments could do is to fund and support Healthy Community projects, both provincially and at local levels, all across this country. Quebec is a long way ahead in terms of

its development of the Healthy Communities Project. It gives me great hope and great inspiration every time I look at what they are doing there.

Developing Personal Skills

One of the most useful things that provincial governments could do is to fund and support Healthy Community projects, both provincially and at local levels, all across this country.

When I talk about developing personal skills for health, I am not, first and foremost, talking about health behavior. I'm talking about what some of us have called basic health - literacy and daily living skills, skills in group process, skills in citizenship. These are fundamental health skills. If you can't read or write adequately, your health in this society is at risk. You won't get a good job, if you get a job at all; you won't earn a good income; you will not understand the warnings in your workplace or the warnings on the food or other products you buy. We are just beginning to understand the health costs of being functionally illiterate.

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Something like one in four adults in this country are functionally illiterate. It's a huge problem, and it's a health problem. I don't think there is any point in talking about giving people health skills in terms of behaviors - not smoking and drinking and so on - until we do this first.

Secondly, we need to develop those personal behavioral health skills, and we need to give our health professions some facilitative skills that will enable them to work with community groups. That's not been the way they have worked in the past.

To sum up, what health promotion needs most of all, if the rhetoric is to be turned into action, is the understanding and health leadership sitting in this hall today. That's the first thing it needs. We need to be advocates for health. We need to stimulate public discussion, and we need to find new partners.

We need to reallocate resources, and we need to find new resources. We need to establish an infrastructure, and we need to build the capacity. That means decentralizing control of the sick care system, establishing health goals, reallocating resources.

We need to be advocates for health. We need to stimulate public discussion, and we need to find new partners.

We need to develop and implement healthy public policies, and we need to address social inequity as a priority. We need to strengthen communities by decentralizing power and control and by supporting Healthy Communities projects.

And finally, we need to emphasize basic skills for health. Only in this way can people truly increase control over and improve their health, and only thus will we achieve health for all.

PLENARY PANEL

PARTNERS FOR HEALTH IN COMMUNITIES

Chair: Gerald Dafoe — **Executive Director, Canadian Public Health Association**
Managing Editor, *Canadian Journal of Public Health*

Panelists:

Jean-Pierre Belanger	**Adjoint au directeur general, Federation du CLSC** **President, Quebec Public Health Association, Quebec**
Madeleine Blanchet	**Presidente, Conseil des affaires sociales et de la famille, Quebec**
Michael Bopp	**Founding Member, Four Worlds Development Project** **Director, Health Promotion Project for the Four Worlds Development Project, Alberta**
Ken Fyke	**President and Chief Executive Officer, Greater Victoria Hospital Society, British Columbia**
Jock Murray	**Dean of Medicine, Dalhousie University, Nova Scotia**
Shanti Radcliffe	**ExecutiveDirector,** **LondonInterCommunityHealthCenter** **Project Coordinator,** **Ethnic Youth and Mental Health Project, Ontario**
Anne Usher	**Chairperson of the Board of Governors, Canadian Council on Social Development, Ontario**

The panelists were asked to speak from their own experience concerning any of the following questions.

- What areas offer the best opportunities for health promotion?
- Who should be involved?
- What are the barriers to health promotion?

Jean-Pierre Belanger

The Dynamics of Local Communities

In working for the Board of Inquiry on Health and Social Services in Quebec, I have had the opportunity to study at some length the model I believe to be implicit in the work being done.

The model postulates two things.

- First, it is not necessarily in the best interest to regard the large health institutions and super-specialized hospitals as an inevitable part of the community system. Once one tries to include them in the community dynamic, the following happens: so complex is their operation, so enormous the problems they must face, that they quickly monopolize all attention and it is impossible to consider anything else.

- Second, a local community does not exist in the abstract. It is part of an environment: a physical, cultural, social and economic environment which naturally has an influence.

At the center of the model, however, is the individual, and that was the most important element developed at the Rochon Commission.

The individual inherits living habits; a capacity for a degree of autonomy, beliefs and values about health; beliefs about his own personal effectiveness, and also beliefs about the effectiveness of the health behaviors that he may or may not adopt. He also has a perception of what the others around him expect in terms of healthy behavior and good living habits.

To recognize the individual's role in improving his own health is not necessarily to fall in the trap of victimizing individuals. On the contrary; if we recognize the influence of the surrounding factors, this becomes a realistic method of assessing the ability of individuals to make the best of things themselves to a greater degree.

To recognize the individual's role in improving his own health is not necessarily to fall in the trap of victimizing individuals.

The second important element of the model is the existence of a natural network around the individual - that is, a group of twenty to thirty significant persons consisting of members of the immediate family, the most important work colleagues, friends, neighbors and so on. There are more and more studies demonstrating the importance of this primary network.

We know the importance of the natural network for resistance to stress and

the ability to face mental health problems, nervous depressions, suicide and so on. But, with social problems, we are also increasingly aware of the influence and importance of the natural networks with respect to support to the incapacitated, especially the elderly.

We know the importance of the natural network for resistance to stress and ability to face mental health problems

For example, studies in Quebec show that roughly six percent of the elderly ought to be institutionalized because of their degree of incapacity. So theory tells us. But in practice, in the field, we find that one out of four of these incapacitated elderly are not in institutions. Why? Because their natural network is capable of meeting their needs, needs which were objectively identified as something only an institution could satisfy.

In the social field, the natural network is also important for support to parents in preventing child abuse as well as in dealing with a handicapped child.

In the social field, the natural network is also important for support to parents in preventing child abuse as well as in dealing with a handicapped child. Therefore, what is important about the natural network is that it provides support to the individual, but it also is a key supplier of services when the individual needs them. Frequently, it is because the natural network is inadequate that people are obliged to call on professionals.

What happens when the individual on his own is not capable of dealing with his problem, and the natural network is inadequate? He must then turn to secondary networks.

What happens when the individual on his own is not capable of dealing with his problem, and the natural network is inadequate? He must then turn to secondary networks. I like to group these secondary networks in the community into three categories.

- Public services.
- Profit-making private services.
- Community groups.

Why classify them this way? Because they have different modes of existence and correspond to different logics of intervention. The logic of public services has to do with rights. That is, the state defines the rights, defines the rules, collects the taxes and pays for the services. The government intervenes directly, and when this becomes the predominant mode of intervention in a community, we have a welfare state. We have experienced this in Quebec, particularly in the '70s - this concept that the state was capable of intervening at the local level and settling people's problems.

There is also a private sector in the health area. In Canada we have greatly preferred developing a public health service, but still we should not forget that between twenty and twenty-five percent of all health expenses incurred in Canada derive from the private system, and not from a system paid by public services and controlled by governments. And this does not take into account everything developing on the periphery of health services which can have an effect on the well-being of the population.

When we attach great importance to the development of private profit-making services to meet the needs of individuals, we are heading

toward a neo-liberal conception of government, whereby market forces are allowed to determine the extent to which individuals can have access to the various services they need, according to their ability to pay.

The third type of secondary network is the community groups. They had been somewhat forgotten - particularly in Quebec - because when the health and social services were being reformed in Quebec in the early '70s, we said that our means of intervention would primarily be the public services. Consequently the community groups were slightly left aside.

What in fact happened, as became increasingly evident with the crisis in the early '80s, is that the government clearly showed itself to be incapable of meeting all needs; now it must develop new partners and even provide those partners with financial support.

But the growth of community groups is a much larger movement which affects all of North America. John Nesbitt noted the significance of this phenomenon in his book *Megatrends* in the early '70s. In particular, he indicated that the "national self-help clearing house" in the United States has already identified 500,000 self-help groups in that country, representing more than 15 million Americans.

Government clearly showed itself to be incapable of meeting all needs; now it must develop new partners and even provide those partners with financial support.

Since that time, the movement has become even bigger. In Quebec, in any case, its vitality and development are becoming more and more evident, and the community groups have really diversified. These include self-help groups, natural helpers, interest groups, groups for the defense and promotion of rights, volunteer groups and so on: a wide range of groups whose overall importance is that they improve the quality of the community social assistance fabric.

The strength of the community movement is that it is founded primarily on interdependence, and on the values of interdependence, with the result that volunteers and paid workers alike will defend with great motivation the rights of the persons they wish to assist and will provide them the assistance with a motivation that is often far greater than that found in the public sector.

It is also important to point out that there is a substitution option here. That is, it is possible, depending on the time and the context, to assign more or less importance and invest more or less resources in either public services or community services.

The strength of the community movement is that it is founded primarily on interdependence.

When there are deficiencies in the natural network around the individual, the necessary support may come from public, community, or other services.

This model is not sufficient to understand what is now going on in the communities because not all communities have the same capacity for action. I would like to briefly summarize for you some studies that have been done in Quebec which show that communities have differing

capacities to support their citizens, and that Quebec can be roughly separated into three regions.

First there are the peripheral regions, with their declining populations and declining community vitality. This is linked to the unavailability of work, which leads young people and parents with young children to leave these regions to find employment elsewhere; as a result, the vitality of these communities is reduced. The individuals who remain age more rapidly, and so there is a concentration of older people who, theoretically, would require greater social support; the latter, however, is less and less available in these regions.

A similar phenomenon, but reversed, is occurring in the centers of major cities. Here it is not a question of lack of employment; on the contrary, jobs are available in great number, but they are characteristically not accessible to the residents of these areas. They are accessible to people with better training who, once they gain access to this type of employment, move into the suburbs, leaving a progressively deteriorating social fabric in the major city centers.

The third sector of Quebec is the development region; it comprises the younger, richer and healthier communities, principally on the outskirts of the major cities and in the regional development centers.

Thus, not all communities have the same abilities to provide assistance. What is notable in the first two communities I mentioned - namely the peripheral regions and the centers of major cities - is that the natural networks are weaker because they are less numerous (fewer people belong to them, and those who do are less dynamic) and so are the secondary networks. That is, public services are frequently less in evidence. Profit-making private services are also less available. It is a matter of markets. If there are not enough customers, the private sector merchants and suppliers of services leave.

Not all communities have the same abilities to provide assistance.

In many places, too, there is a smaller community agency presence because the community is less dynamic. At this level, it would be wrong, for example, to think that local community health problems can be corrected simply by offering community agencies universal and non-specific grant programs for an entire area, because it is probably the most dynamic communities that will be able to develop projects more easily and obtain available funding.

Now, what are the possible intervention strategies at the local community level? It is important to continue to reinforce individual autonomy to the maximum. The efforts already under way must not be stopped. But it is clear that, at this level, one quickly runs up against limits, and that it is particularly necessary, as a second element, to increase the support capacity of the natural networks. And this is possible. There are instances of intervention beginning to develop whose effect is to reinforce the support

capacity of the natural networks.

A third element: we should be as much concerned about the health of communities as about the health of individuals. When the community is sick, it is not able to provide adequate support for individuals in need. At this level, I think that what is important is to concentrate interventions and resources in the areas that are most vulnerable.

We should be as much concerned about the health of communities as about the health of individuals. When the community is sick, it is not able to provide adequate support for individuals in need.

A fourth element: certain global problems, such as unemployment, obviously affect society as a whole. The ideal would be to have full employment policies; but we cannot wait for this before taking action at the local level. We must therefore try to develop alternative strategies and community initiatives at this level.

Certain global problems, such as unemployment, obviously affect society as a whole.

Another element is that public services must be oriented toward community health problems. In Quebec we are lucky: Quebec is still the only region that has a complete support network for public community centers which provide health, social and community services. Lucien Bosinie wrote an interesting article in the *Journal of Public Health Policy* last fall on the evolution of the local community services centers in Quebec.

Public services must be oriented toward community health problems.

And a final element which is important: developing collaboration with the community agencies, which especially includes adequate funding. It is not only ad hoc funding that has to be renegotiated every year of six months. Also included is recognition of the expertise of the community agencies and of their status as equal partners.

Madeleine Blanchet

Objectives, Means and Resources

The greatest of our challenges is that we are advocates of life, of vigor and vitality, whereas the health care system is based on people's fear of death and old age. But what do you expect? We human beings are afraid of death and old age, and we are prepared to put more money into the struggle against them, even if it's a hopeless cause.

We are prepared to have all our organs replaced so that we can live longer. In principle, we can live to age of 120. So how is it the life expectancy is only 80 years for women and 72 for men? And only 60 years with good health? This seems to me to be the real objective of disease prevention and health promotion: to increase the health assets that we all have and that we all develop so poorly. Therefore this seems to me to be the first objective.

The second is to reduce, not at the individual but at the community level, the inequities which persist, even though we are in our eighth year of economic growth in Canada. Our council has just published a report which demonstrates this persistence and shows that, even in a time of economic growth, there can be an increase in poverty and in phenomena linked to this poverty that will cause us to fall short of our goal of reducing inequalities if we are not attentive to them.

Health promotion is equivalent to social development, but first we must combat the factors of poverty, not just economic poverty but cultural poverty. Ours is a country of many immigrants. There will be more and more of them. Ours is a country with a substantial poverty burden. There are 300,000 welfare recipients in Ontario, 600,000 in Quebec. There must be reform to diminish this burden of dependency.

Health promotion is equivalent to social development.

In Quebec, 45 percent of the population is dependent on the government for its subsistence. This burden of dependency is absolutely enormous, and if we do not manage to counter it through our public health efforts, I am convinced that we will fail in one of our main objectives, namely the reduction of inequalities in health.

But what means do we have at our disposal? Almost all of us in this room are professionals. We were taught, first, to treat the illness, and second, to try to maintain people in good health. The activities and accomplishments in the field of public health are very often of an individual nature. Political action and lobbying are not easy for us, because we never learned how to do them. We learned other things.

But here we are required to transform ourselves into quasi-lawyers and go and convince the decision makers. This is not so easy, and it has many repercussions on our public health services.

One of the basic problems was that we are using professionals whose training has given them a very individual perspective.

From having worked just a short while with the people on the Rochon Commission, I realized that one of the basic problems they were facing was that, throughout our system, we are using professionals whose training has given them a very individual perspective. I hasten to add that there is nothing wrong with that perspective; however, if we truly want to affect the life of a community or a neighborhood, we will have to act differently from the way we do now.

But what resources will we use? Traditionally, all our services are paid by the government, but it is very disturbing to see that over the last fifteen years, the federal government has reduced its contribution to the payment of health services from 50 to 39 percent. We do not know the figure for social services, but one can imagine that there has been a decline at least as substantial.

At present, the burden of health care is absolutely enormous, and with the aging of the population and the rise of technology, it is not true that we are going to be able to continue investing a great deal of money in public health services.

A large share of the funding will have to be private.

I therefore offer the idea that a large share of the funding will have to be private. This has already begun. We see the health promotion programs in businesses: this is private sector money. The media have launched many initiatives: these too are privately funded.

If we want to work to further life, if we want to work against inequity, if we want to use means that we do not now have but which we can acquire, we will have to organize ourselves differently.

To summarize, we are going to have to agree very closely on our objectives. If we want to work to further life, if we want to work against inequity, if we want to use means that we do not now have but which we can acquire, we will have to organize ourselves differently.

Finally, we are going to have to push in certain directions for private funding. And (as in the case of the insurance companies, for example) I think we can now be very optimistic in this regard because the message we have been sending the public in recent years has been picked up by the opinion makers.

And we must work with them - with the natural leaders of our society - because we have the expertise in this area of disease prevention and health promotion to make that society better, more equal, and healthier.

Michael Bopp

Spiritual Barriers to Health Promotion

About seven or eight years ago, I was living in Central Africa, and I looked across the street. It was a very dusty street, and there were some kids playing on a rock - it was quite a big rock, big enough for three kids to line themselves up in a row - and they had a steering wheel from an old truck. The first kid in the front had the steering wheel, and he was the driver. I guess it was a bus because another kid was trying to take the ticket from the third kid who wanted to get on the rock. They all climbed on the rock, and they all made "pfffsssst" noises, and they were driving.

I went out and took a picture of it, and I put it up in front of my desk. I have it there now, and it reminds me of our efforts in health promotion: a little bit unrefined in a lot of ways - at least from the standpoint of the people in the communities that we serve, at least that I am involved in trying to serve.

The program I work with began in 1983 as a result of a gathering of native elders and community leaders who wanted to address the issue of alcohol and drug abuse. It was a very different kind of meeting from this one.

People sat in a circle, and they prayed before they began to talk, and when the first old man stood up to speak, he held an eagle fan in his arm. He talked about alcohol and drug abuse being a tree, and how the tree spread it branches over all of the people, and it cast a shadow over all of them. And how the roots of the tree went down into the soil, and the roots were poverty and sexual abuse and poor education and welfare and loss of culture.

When the first old man stood up to speak, he held an eagle fan in his arm. He talked about alcohol and drug abuse being a tree, and how the tree spread it branches over all of the people, and it cast a shadow over all of them. And how the roots of the tree went down into the soil, and the roots were poverty and sexual abuse and poor education and welfare and loss of culture.

And then he said, "Now, you can't just chop the tree down because if you do, it's like a willow; ten other trees will just grow up." He said the other thing about the tree is that you could say diabetes or poverty or poor housing is the tree, and then you could say one of the roots is alcohol abuse; one of the roots is poverty.

You began to get the picture that what we were talking about is not a causal thing at all, but a relational thing. It was the first glimmer I got as a person educated in the Western scientific tradition that there is another way of understanding the whole problem of health promotion.

What we were talking about is not a causal thing at all, but a relational thing.

That brings me to the issue of refinement. As I went into communities trying to be a professional and to support community healing and community change - by the way, the team that I work on is mostly native people; I am one of the few non-native people - I began to realize

increasingly how arrogant I was: how I really thought I had the answers; how I really thought that my science, my training, my Ph.D. had put me in the position of being the expert. Now, all my friends call me a recovering expert.

It took me a few years to realize how patient and loving and kind the community people were that I was working with, and gradually, I began to feel like a helium balloon in the hands of a child. The balloon is floating, and the child is distracted, and he might let me go any minute, and I'm gone, because my only nebulous tie to them and to their world and the process of health promotion and the transformation of the social climate that is creating either health or not health is that little string of my heart connection to those people.

Heart - caring - love. I know those are not very scientific terms. But I was forced to look inward. As a professional, I was forced to look inward and ask myself, "Where does this arrogance come from?"

I looked into it a little further, and one of the surprises that came to me - I guess I learned it first in Africa when I looked out the window and realized there were a lot of black folks out there - was that I used to think that all these other guys, *"les gens qui parlent le francais ou les autres langues,"* and people with darker skin than mine, or people who eat different food than mine or wear different clothes than mine, they've got culture. And I've got reality; I've got the scientific method, moreover.

We have a tradition that comes out of Plato: Socrates is giving instructions to Glaucon, and he says, "You go down in the cave after you've been educated by me and other philosophers, and then you're going to see 10,000 times better than the inhabitants of the den." We kind of believe that as experts trained in our universities and colleges. We go into people's communities and into their lives and into their families, and we think we understand a hundred times better that they do what's really going on. The fact is that I didn't know; I did not understand what was going on in the communities that I was working with.

We go into people's communities and into their lives and into their families, and we think we understand a hundred times better that they do what's really going on. The fact is that I didn't know; I did not understand what was going on in the communities that I was working with.

And I gradually learned that about 5,000 years ago, Europeans were conquered. We were conquered by a very warlike people, but before that we had a much different kind of society that tended to balance male and female perspectives, that tended to be more concerned about nurturing and development of spiritually and the things of the heart and inner things than things of war and things of conquering and things of dominance. And gradually, as we became a dominator society, we developed a science that was a way of knowing. So is Shamanism a way of knowing. There are a lot of different ways of knowing, I've come to understand.

Our way of knowing - our science - is addicted, or is predilected perhaps, to control and prediction.

Our way of knowing - our science - is addicted, or is predilected perhaps, to control and prediction. I'm nervous when I can't predict and control

what's going on. I get into community situations, and I try to predict what's going to happen, and if I can't, I try to control it.

I have created with other people, together with some of you maybe, institutions and organizations that are supposed to serve community health development processes but that are functioning like an addict. We are addicted to a process of control. It's practically impossible for us, institutionally, to give control away. In fact, I don't think you can give control away. I think control has to be taken, in a way, and we have to let it, to allow that or facilitate that process to happen.

I want to make two points, and then I'll stop, two points and a story.

First I want to point out that the process of transforming the context that gives rise to health is a major social change: we're not talking about rearranging the deck chairs on the Titanic. We're talking about reorganizing the way we interact with one another, with our families, in communities. We're talking about building community.

The process of transforming the context that gives rise to health is a major social change: we're not talking about rearranging the deck chairs on the Titanic. We're talking about reorganizing the way we interact with one another, with our families, in communities. We're talking about building community.

I remember when the elders at that first meeting talked about how individual healing and community healing had to go hand in hand, I was totally baffled. What the heck is community healing? What is a community? I didn't know what a community was. I didn't grow up in a community. Not really.

In a community, you sense a warm embrace of love that people have - that they are in. They're in it like a fish is in water.

This is a tip. If you really want to understand the process of health transformation, look at what native communities are doing today. I think they're in the lead. If they've got a lot more guts than we do. They're facing, on a very bottom level, the possibility that society can change, and they're in the business of transforming themselves. They're really doing it.

If you really want to understand the process of health transformation, look at what native communities are doing today. I think they're in the lead.

The two points I want to make are, first of all, that we don't know very much about the process of human transformation, and that there is a new science of human development that is emerging. It is very complex - very much more complex than we thought. And we're not going to be able to get at it from sociology or anthropology or medicine, or any one discipline. It is a multidisciplinary approach that's going to be needed.

The physicists and the biologists are contributing as much as anybody to understanding what these processes are, but so are the old people in the communities; so are the ladies on welfare in downtown Montreal or Toronto, and we have to learn to listen to them.

We don't know very much about the process of human transformation...The physicists and the biologists are contributing as much as anybody to understanding what these processes are, but so are the old people in the communities; so are the ladies on welfare in downtown Montreal or Toronto.

Institutionally, we're not very given to this. We have a lot to learn about facilitating, a lot to learn about humbling ourselves, a lot to learn about listening.

That brings me to the second point. Institutionally, we have some learning to do from the women among us. I'm talking about whether you're in government or whether you're in an NGO or whether you're a community-based organization that is supposed to provide support and assistance and nurturing. That's a very feminine term, isn't it? If you're a dominator you want to monitor and control; you don't want to nurture, and our institutions tend to have a momentum that is male-dominated, that tends to be oriented that way.

Institutionally, we have some learning to do from the women among us.

If you're a dominator you want to monitor and control; you don't want to nurture, and our institutions tend to have a momentum that is male-dominated,

In order to learn to be nurturing, we're going to have to look within. We have some healing to do ourselves within our own organizations. We need to go through a process of revisioning and reconnecting ourselves with what it is to be human beings. And within our institutions and organizations, within our little work groups - even if it's just two of us - we need to begin the process of creating healthy organizations.

We have some healing to do ourselves within our own organizations...and within our institutions and organizations, within our little work groups ...we need to begin the process of creating healthy organizations.

My university, for example, is a zoo. It's slimy politics. It's backbiting; it's undermining; it's critical; it's negative; it creates such stress in people that I'm sure we're creating cancer and diabetes and heart disease and all sorts of other things.

We are an addictive organization, and it's sick. My friends who work in government feel the same way, and so do my friends in many non-government organizations and in community organizations. People are driving themselves in the paper chase - addictive, driving behavior.

How can we promote wellness in organizations or in communities or in families if we're sick? We can't. There's the rub, and it's going to be hard. It's easy to say but really hard to do.

"Why should we trade what we've got for what you've got? What you've got is sick."

This comes from an old lady in one of the communities I work with. She said, "Why should we trade" - meaning Indian people - "Why should we trade what we've got for what you've got? What you've got is sick."

She went on to say, "Look at the welfare system. The welfare system is addicted to poor people. The welfare system needs us. We try to get off welfare and there are all sorts of blocks that prevent us from getting off it!"

"Maybe they got sick," she said (she was talking about her own people), "because we were addicted to alcohol and they were trying to help us, and so it's sort of sickness by association."

She said, "They're so sick now, they can't help themselves. They need intervention. And the only way they're going to get better is if we help them."

And she went on, "The first step is for us to get better ourselves; to get stronger and more independent and to have more vital, more spiritual,

more grounded and more unified lives." Then she said, "We have to include these people in our deliberation. We have to create a circle that includes them in a healing process."

For us, as professionals, that means we have to spend a great deal of time going back to school, but to the school of community, to the school of the family, just listening to people. Listening, listening, and listening and humbling ourselves and looking at ourselves and looking within.

"The welfare system is addicted to poor people. We try to get off welfare and there are all sorts of blocks that prevent us from getting off it!"

I want to close with a story. It comes from Phil Lane Junior, the coordinator of the Four Worlds Development Project. He's a La Cota, and the story goes like this:

"The first step is for us to get better ourselves; to get stronger and more independent and to have more vital, more spiritual, more grounded and more unified lives."

One day the Creator gathered all the people together - all, that is, except the human people. He gathered the otter people and the salmon people and the beaver people and the eagle people. He gathered all of these people together and presented them with a problem.

He said, "I have a wonderful gift. I'm worried, though, because this is the gift of creation. This is the gift of healing. This is the gift of life. And I'm worried that the human people are going to find it, and they're not ready for it. If they get hold of it, it's a very powerful gift, and they're going to mistreat it. They're going to do very bad things with it, so I want to hide it for a while until they grow up a little bit. But I don't know where to hide it."

The Salmon said, "I will take it to the bottom of ocean to the farthest, darkest part of the ocean in the deepest, darkest cave and I'll hide it there. They'll never find it."

And Creator said, "No, they're going to find it there. One day they're going to make machines that will go down, and they're going to find it."

The Eagle said, "I will fly it to the highest mountain, far, far beyond the place where any human being could ever go, up on the wind-swept, snow-swept peaks. I'll put it there."

The Creator said, "No, they're going to make machines that can fly, and one day they will go up there, and they're going to find it."

Buffalo said, "I will take it to the heart of the prairie, far, far to the center of things where only grass and wind goes, and I will hide it under a little clump of grass, and they will never find it there."

And Creator said, "No, one day they're going to go there and they're going to dig it up, and they're going to find it."

The Mole said, "I will take it down, down, down where no mole goes down, down, down to the center of the earth and I will hide it there."

"No, no," Creator said. "One day they're going to dig down deep in there. They're going to be looking for rocks, and they're going to find it."

And it went on and on like that. They talked and they talked, and then a long silence fell upon all of the people gathered there. Then the Creator looked up and smiled, and when the Creator smiles it's like the sun is shining. He said, "I know where we will hide it. We'll hide it within them, They'll never look there!"

Ken Fyke

Health Promotion and Health Care Institutions

Over the last 40 years or so, Canada has made very major strides in public policy concerning health care from the viewpoint of accessibility, universality, portability and cost of administration for the hospital and the medical care sector.

And, contrary to recent media hype about the crisis in health care - meaning hospital care and medical care - there is no crisis. There are problems, but these problems afford opportunities - the opportunity to redefine the real issue and to shift priorities.

The problems that we read about in the press, such as the shortage of beds and crowded emergency departments, are actually symptoms of the real problem, and that is our approach to health care. Our focus on illness, technology and treatment encourages inappropriate utilization of hospitals and medical services.

Governments must take the initiative as they have done in the past. Governments gave Canada its first hospital insurance program in 1947, its first medical care insurance program in 1962. And now, we must redefine our goals. We need to broaden our focus on health.

The health system, with hospitals as a key factor, has permitted us to make great strides in the treatment of illness. But, in the process, we have lost sight of the true objective of health and wellness.

The health system, with hospitals as a key factor, has permitted us to make great strides in the treatment of illness. But, in the process, we have lost sight of the true objective of health and wellness.

The future health care system will be very different from the present. In the future, the important factors in the concept of health will be recognized as self-esteem, purposeful living, energy and the abilities to cope and to change.

The future health care system will be very different from the present. In the future, the important factors in the concept of health will be recognized as self-esteem, purposeful living, energy and the abilities to cope and to change. This statement is now beginning to be understood. And, when it is fully accepted, we will see changes in our health legislation, in the mission statements of our hospitals and the education of health care practitioners.

Three challenges in health promotion are promoting a health standard of living for all; promoting healthy lifestyles; and, promoting healthy environments.

These changes will ensure that we, as a society, can deal with the three challenges that I believe must be phased through health promotion. These are: promoting a health standard of living for all; promoting healthy lifestyles, and promoting healthy environments.

Climbing this new mountain is a challenge for all health care disciplines. I believe that no one group or organization has a monopoly on health promotion. Health promotion requires that individuals affected by the

No one group or organization has a monopoly on health promotion. Health promotion requires that individuals affected by the decisions be involved in these decisions.

decisions be involved in these decisions. Whether we are in the role that provides care or one that prevents illness, we must reassess our approach.

We must undertake our role in a manner that integrates the process of health promotion. I believe that cooperation is the key word. Let us not now, and let the public health sector not now, start worrying about turf. I hear [people say] that our time has come, and I believe this is wrong. Hospitals must change their views of working with the community; but hospitals and physicians must be involved in the transformation we are discussing.

Hospitals and physicians must be involved in the transformation .

There are three initiatives I believe should be undertaken by government or encouraged by government. There must be a redirection of funding from the current system towards measuring outcomes and benefits from the current hospital procedures and technology. It is time the public demanded of hospitals to defend more rigorously the introduction of new technology and new procedures from an effectiveness and cost viewpoint.

It is time the public demanded of hospitals to defend more rigorously the introduction of new technology and new procedures from an effectiveness and cost viewpoint. We must encourage innovation through incentives and funding policies to restructure the system toward a health orientation.

We must encourage innovation through incentives and funding policies to restructure the system toward a health orientation. Let us define the barriers to health promotion, and deal with those barriers.

And, we must ensure that current and future public policies, whether they pertain to highways, forests or social services, be made in light of their impact on health. Furthermore, by promoting appropriate and cost-effective care, it should become possible to shift resources from treatment programs to meet the challenges of promoting a healthy standard of living, health lifestyles and environments.

By promoting appropriate and cost- effective care, it should become possible to shift resources from treatment programs to meet the challenges of promoting a healthy standard of living, health lifestyles and environments.

The challenges are by no means small. We must not underestimate the political realities we are facing when we mention the directional changes that we want to see in our health care system.

But we must do this with understanding; we must do this with education. Blaming or hostility toward the current players in the system will not work. Many players in the care system do want to see change, and I ask those people in the community programs to support and work with the care system to bring about this change.

I have confidence that we have an excellent health care system in Canada, and I do believe that Canadians have the commitment and the drive and the creativity to truly achieve health for all.

Jock Murray

The Role of Medical Schools in Health Promotion and Barriers to the Success of Health Promotion.

Although we are often seen as being as rigid as other aspects of the health care system, medical schools are changing in their attitudes toward health promotion and other broader concepts. We are making serious attempts to broaden the view of our medical students who will be the physicians of the next generation.

We are making serious attempts to broaden the view of our medical students who will be the physicians of the next generation.

For example, we have addressed the curriculum and the matter of how much involvement there is in teaching in the areas of health promotion and prevention. Also, half of our students now spend their time in the community. At any one time, half of our learners are out in the communities relating to practices in agencies and community hospitals.

In addition, a third of our senior students are doing their elective projects in other countries. I think all of that is broadening their view, and that allows them to accept these new ways of looking at health as opposed to illness.

There is another way that the medical school plays an important role. I hope, as you develop your programs, you'll remember the need to collaborate and cooperate with those individuals who have developed expertise in community epidemiology and preventive methods and in biostatistics and the methodology to do the kinds of research that are necessary.

I want to make a couple of comments on potential barriers. If we want to see the success of the tremendous potential for health promotion, I think we should be careful in a few areas that I have heard mentioned at this symposium.

I have heard some important concepts, and I did get some new ideas and views that I think will be important in changing the way the medical school runs. I have heard some things I think will be seriously challenging to our thoughts. I think the things that will be done by CIAR in the area of population health may, in fact, truly be revolutionary in the way we approach these things.

I have heard an awful lot about the fact that we, as physicians, are bad guys.

I also wonder about some of the things I have heard. I have heard an awful lot about the fact that we, as physicians, are bad guys. And I have heard a

lot of the "we-they." I even thought I heard that the 4,000-year tradition of caring for the sick was misdirected. I don't think you said it out loud, but the message seems to pervade.

I heard a paradox. The paradox said that the active health care system is a problem, and yet we want a strong, active health care system.

I heard a paradox. The paradox said that the active health care system is a problem, and yet we want a strong, active health care system. I heard people say that they want to reduce the emphasis on the active health care system and even take away money from the health care system to promote other programs that are equally important. On the other hand, they want it to be there tomorrow when they get sick.

I'm reminded of Ambrose Bierce, the cynical lexicographer who, in his definition of a physician, said he was one on whom we set our hopes when ill and our dogs when well.

I was a little concerned, and I think this is a potential barrier.

I have heard that health promotion is so obvious that we don't need to prove the case, and I think that is a serious barrier to some of the important steps that have to be taken. The same kind of rigid, scientific, objective studies need to be done in many of the areas, and if they're not, then I think that will be a barrier to success.

Those of us who are involved in that other aspect called the health care system - or the sick care system - we talk about side effects and complications. I didn't hear anybody talking about the complications of health promotion, but there are some, and if we don't address them, I think that will become a barrier, too.

Is it not possible, for instance, that misdirected self care will increase the illness of the population? That is possible. It can divert energy; it can divert money; it can increase the medicalization of life processes, and, in fact, it can increase the pressures on the health care system. We have to address those things, or they will become barriers.

I believe in the concept of health promotion. Our medical school has publicly stated its support of these programs and has supported the concept in the province of Nova Scotia to fund these kinds of programs. We have pledged our support for them. But, because I support health promotion, I feel that we must seriously address some of these potential barriers or we will limit our success in this whole area.

We recognize the limitations, both of our system and also of the medical schools, but we do believe that we are a partner in the process.

In closing, I would emphasize that we recognize the limitations, both of our system and also of the medical schools, but we do believe that we are a partner in the process.

Shanti Radcliffe

Equitable Access to Health and Social Services.

The health and social services system, at least for members of diverse cultural and racial groups, could be characterized as a situation of two solitudes.

"Two subdivisions - mainstream and ethnospecific - exist side by side, live somewhat separate existences, hardly take account of one another in their effort to plan and deliver services, and do not account to one another for their plans and activities. This condition of two solitudes must be addressed for members of minority groups to have equitable access to health and social services."

That paragraph comes from *A Time for Action*, which was a major study on access conducted by the Social Planning Council of Toronto.

My own interest is in those members of our communities who have difficulties of access to health and social services, and my experience is with seniors and the multicultural community - the fastest growing segments of our society.

The points at issue for us are:

- Reducing inequities in health status and life chances among different groups of a community.
- Insuring that socially disadvantaged and isolated persons have access to the supports and resources they need to participate in decisions affecting their well-being.
- Pursuing health strategies that empower families and local community groups in identifying and meeting their own health needs.
- Redirecting health resources to improve the integration of health services with community-based services in meeting these needs in the most efficient manner.

I am going to address numbers two and five of the challenges that have been identified: increasing community participation and reducing inequities.

For multicultural communities, the most significant barriers to clients' access have been identified as availability of information, language barriers, cultural appropriateness of service and the difficulties of referral.

What are the barriers to linkages between mainstream organizations such as hospitals and ethnic communities? We could look at it in two ways: clients' access to services and group access to service organizations. The former addresses the question not simply of whether the services are available to individuals, but also of whether there exists a reality of access for the consumer of services. The latter - group access - addresses the question of whether ethnic group members and organizations participate in the planning, delivering and development of services in an integral way.

For multicultural communities, the most significant barriers to clients' access have been identified as availability of information, language barriers, cultural appropriateness of service and the difficulties of referral. Barriers for other groups include geography and lack of transportation in the case of seniors, and long waiting periods for those requiring counselling.

I would like to concentrate in this presentation on the second barrier: group access to service organizations. Taking the perspective of a member of the community, I would like to pose a series of questions that need to be addressed to the chief purveyors of health care in our communities, be they hospitals or other organizations providing health-related services.

The first question is: does the hospital or institution truly reflect the community it serves in structure, personnel and service?

Does the hospital or institution truly reflect the community it serves in structure, personnel and service?

A first step in determining this would be the development of a community profile and a client profile, using available census and other data. It should then be possible to determine why some populations in the community use the services in the numbers that they do, and why others use them less or not at all. This information could then be used in regular service planning and evaluation.

Question two: how can the hospital improve its outreach to under-served members of the community?

How can the hospital improve its outreach to under-served members of the community?

One way would be to review the promotional and teaching materials currently produced and allocate funds, if necessary, for translation or adaptation of these materials. Another would be to encourage community consultation and citizen participation. Creative linkages can often be developed with community groups, sometimes on a twinning basis, in the modes of case coordination, program planning, personnel practices and direct service.

Question three: for ethnic populations, does the hospital have a policy on interpretation practices?

It is important that interpretation be provided by professionals working to recognized standards and that funds are budgeted annually to meet these costs.

Question four: does the hospital provide culturally sensitive service?

For ethnic populations, does the hospital have a policy on interpretation practices?

Representatives of minority groups need to be invited regularly to staff meetings and in-house staff training sessions to discuss their health and social concerns and their resources. The process should also involve representatives of other under-served groups.

Question five: does the hospital have minority representation at other levels and functions of the institution?

Does the hospital provide culturally sensitive service?

Boards and volunteers should reflect the client profile of the catchment area, and pro-active policies need to be developed to recruit such input in planning and implementation. Joint arrangements on a project or program basis are often possible with community organizations.

Question six: does the hospital have an active policy on employment equity, including access to jobs - particularly in supervisory roles - opportunities for promotion, and treatment in the work environment?

Does the hospital have minority representation at other levels and functions of the institution?

Pro-active recruitment strategies, participation in service evaluation, culturally diverse interviewing panels and work-related training sessions would all help.

Does the hospital have an active policy on employment equity, including access to jobs, opportunities for promotion, and treatment in the work environment?

In conclusion, it is important that health and social service organizations do not simply mirror the inequalities existing in society.

Ethnospecific and other community-based groups act primarily as brokers and advocates supplying supportive counselling and advice, information and referral. If their role is to be strengthened into that of a true service partner, built on community ownership and responsibility, some fundamental changes are required.

It is important that health and social service organizations do not simply mirror the inequalities existing in society.

- Firstly, in education: to merge health issues and agendas with community group issues and agendas, to create grass-roots support for change, to build coalitions and networks as required.
- Secondly, in policy: to develop the process of resource allocation, goal setting and plan formulation at both the government and institutional level, and to increase health promotion activities by participation.
- And finally, in funding: target funding to community organizations to assist them to make connections on behalf of their clientele with health deliverers, and to mainstream organizations to encourage sensitivity to the needs of specific populations and to encourage organizational change.

Anne Usher

Social and Economic Equity

I am a registered nurse. I trained in a hospital 30 years ago in Montreal. I became a community organizer, and the best thing that ever happened to me was that the Order of Nurses of the Province of Quebec recognized my eight or ten years of employment as a community organizer outside of the health care system as bona fide nursing and kept my license active and alive.

One story I'd like to share with you from my own experience in health promotion was in that role as a community organizer working with senior citizens in my own home area of NDG in Montreal. That area has a 70,000 population base with 23 percent of the people over the age of 65, with a one percent vacancy rate in apartments and rental housing, and no public housing for seniors at that time - this was back in the early '70s.

One of the most productive health promotion exercises I've ever been engaged in is tenant organizing. By organizing the elderly tenants in our community, we have kept the rents down (that means more money for food) and a lot of people feel more powerful. There have been real victories in that. It's rather simple.

We have seen the development of support networks from the meetings in the buildings that we organize the tenants in, and they have had great benefit to their lives; and besides, people have had a lot of fun doing this.

I have listened to talk about the barriers and the opportunities for greater participation in health promotion and what action is being taken to reduce those barriers. What I hear is beginning to sound very much like what I hear in my own world of social policy advocacy because what I'm hearing translates to me as wages and incomes policy, adequate income definitions, child care, affordable housing, et cetera.

That's our usual agenda in the social policy world, but we too have been rethinking our strategies, and even the change of name of my organization might give a hint of that. What's challenging us is going beyond the welfare state to a new paradigm or organizing concept to guide our efforts in advocacy and promotion of social change.

The development of new directions in social policy becomes more difficult as one moves from concerns for the individual to those where the locus of control of action is shared or more resident in society.

You talk very much about the shift of responsibility away from institutions towards community, informal groups, the family, individuals and prevention. Prevention in my world is very much a key word, too. We talk a lot about developmental strategies, empowering and about that resulting in more power and more choices for people.

The development of new directions in social policy becomes more difficult as one moves from concerns for the individual to those where the locus of control is shared or more resident in society. You can talk about the care of the elderly, or the integration of the disabled into the economic mainstream. We can also talk about the availability of well-paying jobs. The solutions seem to involve a sharing of responsibility, the development of community resources and the provision of targeted rehabilitation and personal development opportunities.

The solutions seem to involve a sharing of responsibility, the development of community resources and the provision of targeted rehabilitation and personal development opportunities.

Recently, in reviewing labor market issues across a number of countries, the Manpower and Social Affairs Committee of the OACD reviewed a concept which seems to be galvanizing individual and collective action. They term it the active society, and while they restrict it in the OACD to labor market issues, it seems to us within the Canadian Council on Social Development to have broader application.

The concept is appealingly simple: an active society does not abrogate the fundamental roles of government, of families, individuals or communities. It does, however, promote a broader sharing of responsibility and the strengthening of private resources. And it's a positive concept. It is also goal-oriented, meaning you can also measure the programs that you develop toward that goal.

An active society does not abrogate the fundamental roles of government, of families, individuals or communities. It does, however, promote a broader sharing of responsibility and the strengthening of private resources.

From my experience on the ground, with seniors and women and working generally in communities, an active society requires people able to participate and organizations to sustain their action, and these are two things that we so very often falsely take for granted.

An active society requires people able to participate and organizations to sustain their action.

The prerequisites to participation have to include a minimum adequate income and a condition of literacy. An expanded definition of literacy that we're using in Canada now includes not only the three Rs and language skills, but also second language skills where the language of political action in the province is not the language of the people there. We also have to know how our world works and how to analyze issues, and that's basic literacy in Canada of 1989.

The prerequisites to participation have to include a minimum adequate income and a condition of literacy.

We must have the human rights framework within which to participate; we have to have the freedom to choose how we're going to spend the time left over from income-producing labor, family-maintenance labor and sleep. Therefore, we need family support systems in our communities to give people that extra time.

We need access to other adults; we can't be living in isolation with our children or as older people. And we need self-esteem. I'd like to remind you that organizations are tools for active people; however, they also require investments of financial and human resources, and they cannot be controlled by outside forces. The attempt to co-opt an organization is going to result in killing the initiative that you're after.

The goal is power sharing and responsibility sharing; and if we're going to do that, we also have to share the credit for what happens. What I would like is to hear a little credit and acknowledgement from people like yourselves going to Canada's gay community and to groups of persons with AIDS for their contribution to health promotion and sickness control.

Many people have recognized that we need this partnership of community and the professions, and it's being nurtured. We still haven't seen, though, a formal recognition within the World Health Organization - a really formal recognition - of the NGOs of the different countries around the world.

The goal is power sharing and responsibility sharing.

I'd like to end by giving you a challenge to become leaders in a campaign that is fundamental to health promotion in Canada. The challenge is to get children out of poverty. I challenge you as active adults with a little bit of extra time to choose how you're going to spend that time and to become those leaders.

What you have to do is learn about the issue, and you have lots of people to learn from. You have the national voluntary organizations that have joined forces to support this campaign. That campaign is investing in families with children. You also have your local organizations that are part of this.

I'd like to end by giving you a challenge to become leaders in a campaign that is fundamental to health promotion in Canada. The challenge is to get children out of poverty.

The national organizations are the Canadian Council on Children and Youth, the Institute for Child Health, the Canadian Child Welfare Association, Family Services Canada, the Child Poverty Action Group (mostly based in Toronto), and the Canadian Council on Social Development. Surely you know somebody in one of those organizations.

Get hold of the material; inform yourselves. Why do I think you're important? Because you talk to your minister, and if you get your minister on board at your provincial level, and he gets his Finance Minister on board, then all together we perhaps can effect fundamental change in how we think about supporting children in this country.

You can't afford not to get on board this campaign. In 1985, out of seven and one half million children in Canada, six thousand died. Another recent Canadian study indicated that the mortality rate among poor children is two times that of families with children at the highest income levels. Also, in a recent Ontario study, children from families that receive welfare benefits had one and a half times the rate of chronic health problems than those experienced by families not on welfare.

You can't afford not to get on board this campaign. In 1985, out of seven and one half million children in Canada, six thousand died.

PLENARY PANEL

PARTNERS FOR HEALTH IN GOVERNMENT

Chair: Susan Brice — **Mayor, Oak Bay**
Chairman, Capital Regional District

Panelists

Marc Dionne — **Quebec**
Directeur, Public Health Ministry,

Mavis Hurley — **New Brunswick**
Deputy Minister, Income Assistance,

Marilyn Knox — **Ontario**
Executive Director, Office of the Premier's Council on Health Strategy,
Ministry of Health,

Rheal LeBlanc — **Alberta**
Deputy Minister of Health,

Blenis Nicholson — **Nova Scotia**
Deputy Minister of Education,

Jonathon O'Riordan — **British Columbia**
Acting Assistant, Deputy Minister Programs,
Ministry of the Environment,

The panelists were asked to speak from their experience in government concerning the following areas.

- Action steps that can be taken to promote the health of Canadians.
- Opportunities for intersectoral cooperation.
- Roles that can be played by various departments.

Marc Dionne, Quebec

The Role of the Health Department

My first reaction to what I have heard at this symposium is that, in order to develop health promotion, public health policies will probably have to continue two main emphases.

The first will be on treating and preventing disease, the primary responsibility for which will lie with government health departments; obviously, public health officials will play an important role here.

The second emphasis will be on developing health promotion so as to ensure an optimum level of health; this will be the responsibility of society as a whole. The aim here will be to create favorable health conditions through the use of multiple strategies and multiple partners, whose concerns will range from how to ensure health-conscious industrial development to the formation of peer or self-help groups for young people in difficulty.

Regarding prevention and promotion strategies, and especially who should take part in prevention and promotion, I would group the interventions needed into four main strategies.

First, community support. Clearly, government health departments and public health officials will have a role to play in developing or making possible favorable health conditions. But there are many other partners who can offer support to the community to ensure such health promotion. Think of the government transport departments which will have to promote the development of safe road systems. Think of the housing departments, of the departments of the environment which will have to ensure the quality of the water supply. Think in particular of the regional development departments which will have to ensure an equitable distribution of resources, jobs and funding across Canada.

There are many other partners who can offer support to the community to ensure such health promotion.

Secondly, the department of health will also play a role in supporting the natural network. In Quebec, we have a highly developed support strategy for community agencies, a system of complementary programs. Think especially of the support we can provide families in terms of temporary accommodation for their elderly or for handicapped children. But also fiscal support. I think we will be developing measures to allow families to continue to be involved in the care of their parents.

The third strategy is the education of individuals. Here, too, the department of health and public health officials will have a role to play

through promotion and prevention campaigns. Departments of educations must be partners in this task so that individuals can better monitor their health. Businesses and workplaces must provide their employees with information on health hazards and on means of controlling stress. Unions must be concerned to create healthy work environments.

The fourth strategy is to create a sense of organizational responsibility. All government departments and agencies must be concerned with health. Regional and municipal governments must be concerned with it. Businesses must be concerned with it.

Who will encourage the involvement of all these partners in health promotion? Here again, the government health departments, naturally. Here again, naturally, public health professionals must influence these partners to become concerned with health.

Furthermore, the press - journalists - must help to develop this concern for health promotion among the other partners. Political groups and parties must include this sort of concern on their agendas. Pressure groups and unions must make their voices heard on the subject.

What types of professionals must participate? I am speaking to you today as a government official who has been promoted to the rank of deputy minister for the period of this conference. I am also speaking to you as a general medical practitioner and as a hospital administrator. But I am also speaking as an individual concerned with justice and social equality.

It seems to me that health promotion is the business of all who are interested in the welfare of the members of society. The surgeon who firmly believes in the effectiveness of the coronary bypass is also a father who will probably need help in taking care of his children. The hospital accountant may also be a municipal councillor who will have a key role to play in developing the "healthy cities" concept.

Health promotion is the business of all who are interested in the welfare of the members of society.

And finally, I think that what we also expect from specialists like yourselves are proposals of short-term operational objectives and longer-term objectives pertaining to the social changes that will be necessary for developing these promotion objectives.

Mavis Hurley, New Brunswick

Challenges for Health Professionals

Goods things are happening in New Brunswick that are allowing us at the senior level to think beyond the narrow parameters of our own department. I think that has influenced our capacity to see the problems that others face and to realize the inter-relationships of all of the many programs that governments must fund in terms of how they can affect people regardless of the good intentions of the ideas.

Goods things are happening in New Brunswick that are allowing us at the senior level to think beyond the narrow parameters of our own department.

I've been surprised and pleased to hear the number of times speakers have said that health is no longer being seen as a hospital, public health, care system issue, but something that reflects many of the missing factors in the broad range of social programs like adequate housing, adequate food, adequate minimum income for all the other necessities, adequate recognition of the trials and tribulations of raising children, et cetera.

I am not hearing the challenge of "we-they." I am not hearing the challenge of hospitals versus community. I'm hearing very much a challenge to each of us to expand our professional capacity and to take on some of the tools of other professionals, particularly maybe those in the education system, and to demand of ourselves a better understanding of the people we are trying to help, the people for whom we are trying to promote a healthier lifestyle.

I am hearing a challenge to the health sciences systems the education of medical staff, the education of all of the health care professionals - a challenge to them to learn to listen and to educate.

When my clients misuse the health system, they are not doing it because they don't know what's right; they're doing it because it is a security blanket for them that says, "When you're in need, whether it's appropriate or not, you can go to that out-patient department or that clinic."

If the health professionals my clients meet there can take the added time to listen - not to answer the question that's asked, but to answer the questions behind that - and take those people that step further along in understanding who they are, we will all have been promoting healthy lifestyles.

Marilyn Knox, Ontario

Visions, Goals and Strategies

I'm hearing a lot about health promotion as pioneer work, and in the true spirit of pioneers, perhaps we can learn some lessons from what we've done in the recent past in shaping a broader approach to health through partnerships.

I'm going to draw from two set of experiences. The first, the Minister's Advisory Group on Health Promotion and the second, the Premier's Council on Health Strategy, both of which are taking place in Ontario.

The first is completed. The Advisory Group consisted of seven people outside the government: six health professionals chaired by a consumer who had a background as a consumer advocate in a specific area, Steve Podborski. We had the ear of the Minister, and that work is done.

The second is the Premier's Council on Health Strategy, and that's a very different example. Seven of the people on the Council are cabinet ministers; 24 are very senior level outside advisors from the health professions, both the physical and mental health side - business, labor, north, south, east, west, male, female, consumer representatives - and, of course, our Chair, the Premier.

The marching orders that we were given were: "Don't study health to death. Goodness knows we know a lot; let's get on with it." And so, the cornerstones that we began with were the Evans Report, the Spasoff Report and the Podborski Reports, as we call them in Ontario.

Our starting point was where the consumer is coming from. In the Minister's Advisory Group on Health Promotion, we learned that the road to health from the consumers' point of view is broad; in fact, we're perhaps catching up to their definition of health.

We learned that they, in fact, are very ready, but often feel at a distance from the people who make the big decisions. And there are certain roadblocks: for example, environment is the thing we hear about the most, but also the stress in their everyday lives; fairness in terms of access to the system; and finally, behavior and lifestyle issues.

Starting from the consumer perspective, we discover that health promotion needs a strategy. Perhaps we need a vision, a philosophical collective drive that helps us understand where we're going, in terms that the folks and the politicians understand.

A vision of health would look at maximizing productive healthy days. It would look at our health as influenced by the role we play at home, at work, in our community; it would recognize that where we live, what we learn, what we earn and what we eat supports us; that access to good health service is important, and finally, that responsibility for health is shared.

Key points could be something like this. A vision of health would look at maximizing productive healthy days. It would look at our health as influenced by the role we play at home, at work, in our community; it would recognize that where we live, what we learn, what we earn and what we eat supports us; that access to good health service is important, and finally, that responsibility for health is shared.

Partners for Health has to be an integral part of the vision.

Second point - goals. We've talked about the need for health goals. We're in the process of setting five major goals for the province, and I think it's extremely important to make sure that the goals that we choose are complementary. For example, if we're looking at reducing morbidity and mortality, we also have to have a goal that interlocks with shifting to health promotion and disease prevention.

Policies: we need new research, new structures and new policy partners. Policy development in the government is a unique kind of a task and is not an easy thing to do. Very different sets of policy makers need to start addressing the policy issues. And we need to develop an intellectual framework against which to develop new policies in this broader context.

Delivery: we need new partners and partners in different locales. This doesn't mean that those in the traditional institutions and community health centers aren't important, but we need to open up our minds, and that needs to be part of the strategy.

For example, we had the good fortune to have Father Sean O'Sullivan involved with us on the Premier's Council. One of the things he brought to that group was the notion of starting where the consumers were, and that plays through in everything you do when you're reorganizing yourself on the delivery side.

Linkages: we need new models, and we need to test them. One of the things we've all been talking about is devolving to local control. One of the things that we have just about completed is a look at some 45 to 50 major reports done in the past two decades across the country that have told us some of these things about devolution of authority, about increasing public participation, about having a broader definition of health, and so on.

How do we get on with it?" We need money.

What we're doing is stopping the process and saying, "What have we learned from all of that, and how do we get on with it?" We need money. We need money for opportunities; and folks, the pot is definitely not full. So, when we're dealing with the politicians, we need to suggest where money can come from so that we can say where it will be reallocated to.

We have set up an innovation fund for $100 million dollars to try out some brand new things.

One of the things we have done is set up an innovation fund for $100 million dollars to try out some brand new things. What we've just found out in our

first round is that perhaps we aren't going to be overwhelmed by innovative ideas coming in from the traditional centers.

And, finally, public involvement. Public involvement needs to be a component in all those phases of the strategy, and that isn't an easy thing to do.

I can tell you that the consumer representatives who have been put on this esteemed council are just now, after many, many months, feeling powerful enough to say what's on their mind. So, I think public involvement is an honorable thing to do, but we have to help people do that well.

And, I think there is some opportunity. We brought in Ron Draper - Ilona Kickbusch's cohort in Copenhagen - early in January to help us work through some things. And I asked him, "How do you think things are going?" And he said, "Well, there's a lot of talk." I said, "Well, is there at least more talk in the country this year than there was a few years ago when you left town?" He said, "Well, maybe."

After a couple of days had passed, he said, "There's something unusual going on here." I think the something unusual that's going on is the fact that, not only where we are, but right across the country, leadership is starting to come out. We need to find those natural leaders who can take our cause further; we need to bridge build - between the professions as well as beyond.

We need to find those natural leaders who can take our cause further; we need to bridge build - between the professions as well as beyond.

And, finally, we need to bring the policy makers closer to the people. Our policy makers need to be close to all of us and to the others out there in order to understand.

Rheal Le Blanc, Alberta

The Need for Collaboration

Over the last two days, I have very much enjoyed the conversation that has gone on in this meeting. It reminded me of the days when I was doing *animation sociale* - social animation - in the Gaspesie and working in front-line communities in the Lower St. Lawrence and the Gaspesie.

That project was the first major socioeconomic study of a large region of Canada. At that time, we were discussing economic development, public assistance, housing, nutrition - all of the issues that have been discussed during this symposium. Possibly the most significant change since that time has been that now we have a broader vision in that we are also talking about the environment, and we are putting all of those issues within the context of health. When I was doing social animation in the Gaspesie we were essentially concentrating on economic development, that being the solution, we thought, for a *renouvellement* of the Gaspesie and the Lower St. Lawrence.

This forum, I think, has to do with priorities and with objectives. When I was reflecting on what I would say, I was struck by an article in the *Edmonton Journal* headlined "Province Blamed." The article said there was a gentleman, a farmer from outside of Edmonton who had to be transferred to Calgary for a surgical operation. The reason was a shortage of nurses. The article then went on to ask, "What should society be providing? What are the priorities?"

In my view, it is essential that all of the participants, however broadly we define them, must work together in a collaborative effort. I do not see any utility in trying to shift resources, change our priorities, unless we do it jointly. In Alberta, we think we have an opportunity to do that by the formation of a new Ministry of Health. We are in the final stages of negotiating what I think is an incredibly significant agreement with our medical colleagues in Alberta. They have, for the first time, agreed to work with us in looking at utilization. The industry is large, the issues are large, the interests are large; but I am very, very confident that by working together we can provide the leadership that is required.

We are in the final stages of negotiating what I think is an incredibly significant agreement with our medical colleagues in Alberta. They have, for the first time, agreed to work with us in looking at utilization.

It is with this hope that I look forward to the next two conferences that are going to be held in Quebec City and in Toronto. Hopefully, at the end of the process, our leaders, be they community or governmental or the non-government organizations, will see the opportunity that by working together we can tackle the very large, important issues that face Canadians.

Blenis Nicholson, Nova Scotia

Building Bridges in Education

There are policy decisions that you are discussing here, but when those are settled, we as educators can play a major part in what you are trying to do; what we are all trying to do, as far as our population is concerned. We deal with people when they are very young; many times you deal with them at a later age.

Children who have a sense of well-being and are healthy can achieve a great deal more, and it makes our job much easier in the school system. But sometimes we are almost in a Catch-22 situation, a chicken and an egg situation. It's very difficult for teachers in some of our schools to teach nutrition, to teach healthy habits, when some of the students are coming from difficult homes, when they're coming without their bellies full. It's very difficult to teach some of these children any health habits.

Those are some of the things we have some problems with.

A number of years ago, our government created what they call the Hess Committee which consists of representatives from the Departments of Health, Education and Social Services. In the past six months, we've added the Departments of Advanced Education and the Attorney General. Social Services has become Community Services.

The committee is made up of the Deputy Ministers from these five departments, and it's amazing the topics that the ministers and Cabinet and deputy ministers put forward to this committee. It's also amazing, or maybe it's not, the overlap in all the topics.

Literacy, for example, is part of our business. It's a health problem, in most cases, because of the standard of living that the people who are illiterate have.

Health is something that hits most of the topics. Literacy, for example, is part of our business. It's a health problem, in most cases, because of the standard of living that the people who are illiterate have.

This committee meets on a regular basis and discusses all types of topics. On our program committees, we try to have individuals from all other departments that are apropos to that particular topic. It's very important that we get a cross section.

When the Task Force on AIDS was put together in our province, the lead had to be taken by the Department of Health. There wasn't any question about it. Some of the first programs that came out were in the school system. But in my opinion, the medical profession within the Department of Health had to be seen to be leaders in this field because the fear of AIDS

is the fear of the unknown. Whether it is right or wrong, the perception is in the community that the doctor has the technical expertise in this and many other areas; in fact, in all areas dealing with health. And, as we know, perception, whether it's right, wrong or indifferent, is very important. As they say, it's 98 percent of the law.

If you were to look back about 20 years ago, the Department of Advanced Education, Recreation, most of Culture, and Fitness all came under the Department of Education. But we've advanced in 20 years. We're all separate now and we have to build bridges so that we don't go off in different directions.

We were given a number of topics to consider and one was: what specific health-promoting policies could be instituted through our department or organization?

I mentioned AIDS as one of them; daily physical activity is another. Another is our safe graduation program. These are just some the aspects of what could be instituted and what is being instituted through our department.

In closing, I want to say that we're educators. We know how to deal with children. If you wish health to be promoted amongst our school population, we have a captive audience. You must work with your departments of education and school boards because most teachers, not all, are role models. They can promote, if they are well trained in good health habits.

In Nova Scotia, all departments are willing to work with all other departments, and even the federal government, to promote health and disease prevention. In education, it's going to make our job easier. But the most important thing is that it's also going to help the future leaders of this country, out citizens, our school children.

Jonathon O'Riordan, British Columbia

Health and the Environment

As a representative of the B.C. Ministry of Environment, I would like to talk briefly about five issues of concern in the area of environmental health.

- Public awareness in environmental health.
- Our interagency coordination.
- Monitoring of the environment.
- The management of wastes.
- Public input to the decision making process.

In terms of public awareness, we're well aware of the polls which tell us that environment has now catapulted to one of the major issues of the day. One of the reasons for that is because the public are concerned about their own personal health, and they feel a threat to their personal health from some of the chemicals that are now in the environment.

The public are concerned about their own personal health, and they feel a threat to their personal health from some of the chemicals that are now in the environment.

It's fair to say that there are probably only two motivators for a social concern. One is fear, and the other is reward. We're finding out that there is a growing public fear of the effects of the environment on public health. We're well aware of that in the Ministry of Environment. So we've developed a number of liaisons with various levels of government; and the main one we've developed over the last year is with our own provincial Ministry of Health.

We've started a number of joint studies on environmental health, one of which has just been announced, to deal with the effects of lead in Trail, where a big Cominco smelting plant is located - the effects of lead in the environment there on health, particularly in school children. We're also working with university researchers in Port Alberni to see what the effects of the pulp mill discharges into the atmosphere have on public health in a town that has been faced with a pulp mill for 20-odd years.

Another area we're going to be looking at in the future is the effects of ozone in the Lower Mainland on public health. It's an emerging issue.

There's a growing concern about dioxins in the environment, and we're working with the federal government, both with Environment Canada and Fisheries and Oceans on that, as well as the health organizations.

And, last but not least, one of the real sleepers in environmental health is contaminated sites. You may not be aware, some of you who were here almost three years ago to enjoy Expo, that you were walking on one of the largest contaminated sites in British Columbia. It's now the subject of a major review and cleanup; and one of the principal issues there is the level of cleanup which will be required to protect the public health from chemicals that were placed on that site some 30 or 40 years ago by a whole assortment of industries.

One of the things we're planning to do in the Ministry of Environment, in conjunction with the provincial Ministry of Health, is to develop a multiple-year environmental health strategy.

There is a wide range of issues to deal with, and one of the things we're planning to do in the Ministry of Environment, in conjunction with the provincial Ministry of Health, is to develop a multiple-year environmental health strategy. We're planning to develop a workshop sometime late this year with representatives from the federal and provincial governments and local governments, as well as academia, to try and work out what has to be done in terms of dealing with environmental concerns.

We also work with the federal agencies in health and environment under the umbrella of the Canadian Council for Resource and Environment Ministers (CCREM) and a joint consultative committee with the federal health people involved in developing standards for various contaminants which will protect public health. We have an on-going process of consultation to develop guidelines for a variety of chemicals.

So, there is a fair bit of interagency consultation going on now, and I think we will be stepping that up over the next year or two.

Monitoring the environment is a key factor, too, because the cost of monitoring, particularly for environmental health and some of these toxic contaminants, is very large indeed.

Maybe some of you don't know, but we're dealing with such minute quantities of elements, such as dioxins, that the kind of thing we're trying to measure is the equivalent concentration of one second in time over 32 years - or something like two feet of wire relative to wire stretched around the earth. We're dealing in parts per quadrillion, and the sensitivity of instruments to measure that becomes very critical. That's the kind of thing that is increasing the costs of monitoring the environment.

We're partially offsetting these costs now because in British Columbia a year or two ago, we announced a policy of charging a fee for waste discharges, and that discharge fee has been used to monitor the environment. We're one of the few provinces in Canada that have a discharge fee policy. And when it come to cleaning up the environment, we have a policy of polluter pays; that is, if we can find the polluters. It's not always that easy.

I want to touch on a couple of issues we deal with in the category we call Special Wastes: toxic chemicals that are of major concern for public health. There are four ways of dealing with these. We can store them; we can recycle them; we can destroy them; or we can export them.

Storage is really not a long-term solution because sooner or later some of them are going to have to be destroyed.

Recycling has limited economic opportunities at this point in time, so it's not a total solution although it's a partial one.

Export has now almost become a non-issue because the borders are closed for the export of many toxic chemicals, both to the States and to Alberta where the only destruction facility in Canada is located.

We're left with destruction of these wastes within British Columbia, and we run into two problems there. One is the cost. We estimate that to control dioxins in the 17 pulp mills in British Columbia which use a bleach chemical process, we're looking at in the neighborhood of a billion plus dollars.

We estimate that to control dioxins in the 17 pulp mills in British Columbia which use a bleach chemical process, we're looking at in the neighborhood of a billion plus dollars.

The other problems we have is trying to find a facility to incinerate or destroy these chemicals. Some of you who are from British Columbia will be aware that about six months ago we had to withdraw a proposal to develop such a facility at Cache Creek. There was a statement in the paper at the time that the Cache Creek farmers won, or some headline to that effect. That may be correct in the short term, but in the long term, I think British Columbians have lost because sooner or later we're going to have to find a place to deal with these wastes, and the Nimby Syndrome is rife in the area. No one wants a destruction facility in their backyard, so it's a major struggle and challenge to find a way of managing these wastes.

That leads to my final point which is: why do we have these wastes in the first place?

At the risk of being controversial, I should point out that the Ministry of Environment's primary responsibility at this stage is to regulate the discharge of wastes into the environment. In a number of jurisdictions, especially in Europe and Britain and to some extent in the States, a new approach is being developed which is called the Best Practical Environmental Option. There the controls are beginning to move back into the manufacturing process.

The responsibility for simply controlling the discharge of wastes into the environment is no longer satisfactory.

The responsibility for simply controlling the discharge of wastes into the environment is no longer satisfactory. We're going to have to start looking at why we have some of these chemicals in the manufacturing process in the first place.

The management of environmental health becomes an issue for all of us, not just for the Ministry of the Environment.

When we start asking these questions, all of us as citizens are going to have to ask what is our demand as consumers for some of these products, because as long as consumers demand products such as bleached paper and the like that require the discharge of chemicals into the environment, there will always be this struggle to manage these chemicals when they get into the environment.

This means that to some extent the management of environmental health becomes an issue for all of us, not just for the Ministry of the Environment.

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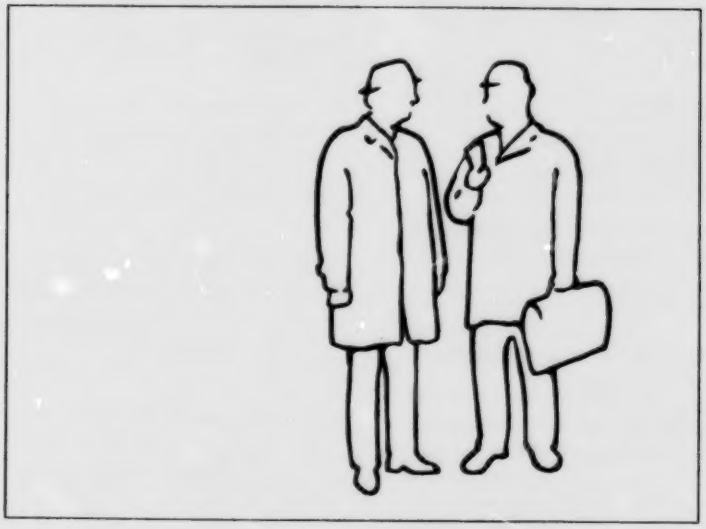

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St. John's, NFLD;
Anne Rowe, B.Sc., M.Ed.
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1.3 Everyone Wins: A Health Education and Promotion Initiative from Saskatchewan
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Community Health Promotion

1.1 Choosing Wellness

Nancy Hall, Ph.D., Vancouver, British Columbia

In August 1988 the B.C. Ministry of Health initiated a project to help communities develop health promotion activities for seniors. The goals of the project are to help seniors living independently maintain their health and to foster a community development approach to the challenge of healthy aging.

Specific objectives include:

* Training professional staff and volunteers in effective community development skills.
* Developing local area planning groups such as a Seniors' Health Council or an Advisory Committee on Healthy Aging.
* Using the community development process to foster the development of mutual aid projects.

To achieve these objectives, the project has promoted intersectoral cooperation among government departments, service agencies and community groups; provided community development training for professional staff; and produced training and information manuals. The province has provided seed money for community initiatives through community development grants.

Success has depended on factors such as finding a contact in the community, establishing clear roles for professional staff, making sure that staff participate in the training provided and not expecting things to go the same way in every community.

1.2 Nobody's Perfect

Marilyn Keddy, Halifax, Nova Scotia
Lynn Vivian-Book, St. John's, Newfoundland
Anne Rowe, Fredericton, New Brunswick

This program was developed as a result of a joint initiative by Health and Welfare Canada and the four Atlantic provinces. It is an education program for a special group of parents with children up to five years old. The target group of parents have one or more of the following characteristics: young; single; low income; low education; subject to social, geographic or cultural isolation.

The goal of "Nobody's Perfect" is to improve these parents' abilities to give better health care to their children. The core of the program is a set of five books designed specifically for the target group.

The program uses adult aducation, mutual support and self-help strategies to produce positive change in participants' knowledge, attitudes and behavior in relation to their children's health and safety. An evaluation indicated that the program has been successful, and plans are underway to implement it on a national basis.

1.3 Everyone Wins: A Health Education and Promotion Initiative from Saskatchewan

George Loewen, Regina, Saskatchewan

The program was launched in 1988 with three major objectives: to increase public awareness of healthy living; to instill commitment and motivation in individuals; and to foster partnership in health education between the community, the government and the private sector.

The program focuses on seven key lifestyle issues: nutrition; physical fitness; stress; accidents; alcohol and drugs; smoking; communicable diseases.

Stakeholder and community interest is growing. An effective logo and song and favorable media support have contributed to the success of the program. Its weakness lies in its association primarily with fitness, its failure to attract much interest in seniors, insufficient field staff involvement and slow development of resource materials.

New initiatives include a stronger visual image for the program, a Health Fair, a syndicated column, a focus on seniors' activity centers, and special summer programming.

1.4 Creative Mental Health Alternatives at Work in British Columbia

Chloe Lapp, Vancouver, British Columbia

A $500,000 government grant to the Canadian Mental Health Association resulted in a variety of new projects, almost 200,000 hours of volunteer time and 3,000 new volunteers. The projects included: curriculum development; workshops on television programming and media training; theatre programs for street kids; support groups for Indo-Canadian women; peer counselling for seniors; self-esteem enhancement programs for lonely children; research on public attitudes to mental health and ways of changing those attitudes; starting self-help groups; and community development.

Heart Health

2.1 Nova Scotia Heart Health Program

David MacLean, Bedford, Nova Scotia

In 1986, the Nova Scotia Department of Health and Fitness conducted a survey which revealed that 71 percent of adults have one or more of the major risks associated with cardiovascular disease. Middle-aged males, elderly females, and those of low socio-economic status had particularly high levels of risk.

In 1988, in collaboration with Health and Welfare Canada, the Nova Scotia Ministry of Health and Fitness initiated the Nova Scotia Heart Health program. This is the only program in North America to form part of the World Health Organization's Country-wide Integrated Non-communicable Disease Intervention program (CINDI).

Nova Scotia Heart Health is a community-based approach to the promotion of heart health and the prevention of cardiovascular disease. Activities will be the result of coordinated efforts by a variety of partners. These include private sector organizations, government departments other than Health and Fitness, volunteer organizations and representatives of health professional bodies.

This is a five-year, province-wide demonstration program. In the later years of its mandate, the scope of activities will be extended to include the prevention and control of other non-communicable diseases, such as cancer.

2.2 Heart Beat Campaign in Ottawa-Carleton

Stephen Corber, Ottawa, Ontario

The goals of the Ottawa-Carleton Heart Beat Campaign are to modify community levels of the three proven cardiac risk factors: smoking, high blood pressure and high levels of serum cholesterol. The campaign uses strategies that combine individual awareness of the risk factors with community activities that support positive lifestyle changes.

Campaign strategies are based on an assessment by the Ottawa-Carleton Health Department of factors that influence people to adopt healthy heart behaviors and of barriers to behavior change. The department also conducted a survey to identify needs and priorities and to establish baseline measures.

Since its inception in November 1987, the Heart Beat Campaign has focussed on developing a high level of community participation and volunteer involvement.

2.3 A Cooperative Heart Health Initiative Among Four Provinces

Chris Balram, Fredericton, New Brunswick

New Brunswick, Newfoundland, Nova Scotia and Prince Edward Island share the highest death rate from cardiovascular disease in Canada. These four provinces are now involved in a cooperative approach to the issue of health health.

Recent heart health studies in the four provinces collected data from 2000 respondents. Results provided information on blood pressure, blood cholesterol, smoking habits and secondary risk factors. The study also produced information about attitudes, knowledge and awareness. These findings will be used in planning, developing and evaluating heart health programs in the four provinces.

2.4 Alimenvi: A Community Approach to Improving Nutritional Milieu

Lise Bertrand
Paule Masson, R., Montreal, Quebec

A comparative study of two districts in Montreal revealed that it was much more difficult to ensure an adequate nutritional diet in the poorer district. Food cost more in this district, and there was less fresh food available. The supply of wholegrain products was also poor.

The revelation of the results at a press conference triggered a number of actions. The major department stores reduces their prices, the municipality introduced fresh produce stands, and local groups developed community kitchens with an education focus. Local schools are also planning a low-cost nutritional lunch program.

New Structures for Health

3.1 Health Plans from Urban and Rural Quebec Communities

Richard Lessard, Laval, Quebec
Diane Plamondon, Beauceville Ouest, Quebec

Since 1984, a number of community health departments in Quebec have been expanding their health plans in accordance with analyses made at the provincial, national and international levels. The objective is to define health goals more precisely in order to improve health promotion and illness prevention.

The plans facilitate analysis of the principal health problems in the territory covered by each department. They also help the departments initiate proposals and provide support for the measures undertaken in each community.

3.2 Strengthening Community Health

Sharon Martin, Vancouver, British Columbia

The Canadian Public Health Association's Community Health Secretariat is part of a national strategy for strengthening community health services. The secretariat was set up to stimulate community activity at national, provincial and territorial levels. Funding has been provided by Health and Welfare Canada.

The goals of the secretariat are:

- Increased community participation in the planning, implementation and evaluation of health services.
- Increased knowledge about community health and improved skills for members of community groups, health professionals and educators.
- Identification of priorities for action.

The idea for the Community Health Secretariat grew out of a series of provincial forums which the Canadian Public Health Association held in the spring of 1987. The forums produced overwhelming consensus that it was essential to support groups and individuals within

communities in defining their health needs and priorities and to give them a stronger role in determining the allocation of health resources.

3.3 The Ontario Alcohol and Drug Framework: Developing and Testing the Prototype for Community Planning

Robert Simpson, Guelph, Ontario

A recent project carried out in Ontario's Wellington-Dufferin health district developed a framework for planning addiction services that divided programs into two components: health promotion and health recovery.

The health promotion component is directed toward people who are not currently experiencing addiction problems. Depending on whether the target populations is defined as "no risk," "low risk," or "moderate risk," programs and services will incorporate either "risk avoidance" or "risk reduction" strategies.

The objective is to be able to tailor the mix of programs, services and policies to meet the particular needs of each of the 28 health districts in Ontario. This approach to planning involves all the local stakeholders and takes into account local concerns and capabilities. The process also includes a method ofassessing the most effective use of available resources. Decision making is by consensus.

3.4 Victoria Health Project

Paul Pallan, Victoria, British Columbia

The Greater Victoria Hospital Society, the Capital Regional District and the Provincial Government are jointly involved in a $4 million program that will test new approaches to health service delivery. The initiative is aimed at improving the coordination of health services at the community level.

In its first ten months, the project has implemented a number of initiatives aimed at promoting independent living and enhancing the ability of clients and caregivers to help themselves.

Community Health Promotion

4.1 Mental Health for Canadians: Striking a Balance

Carl Lakaski, Ottawa, Ontario

In 1988, Health and Welfare Canada published a discussion paper which defined mental health as a resource for living. *Mental Health for Canadians: Striking a Balance* identifies three major challenges: reducing inequities related to age, sex, ethnicity and race; increasing prevention of mental disorders and poor mental health; and enhancing the ability to cope with disabling conditions and the major transitions in life (e.g. from childhood to adolescence).

Striking a Balance recommends a set of guiding principles which could change the nature of services and programs related to mental health. These principles are concerned with issues such as human rights and citizenship; mutual aid and voluntary service; consumer participation, and strengthening communities.

4.2 Occupational Health as an Agent of Change

Joe Leonard, Toronto, Ontario

LAMP is an independent organization in an area with a heavy concentration of older "smokestack" industries. It is devoted to improving health conditions in the work place. Careful diagnosis and follow-up of individual workers and effective group education programs have resulted in worker clients taking a leadership role in improving health conditions in their workplace.

4.3 The Waterford Hospital School Visits Program

Sharon Barnes, St. John's, Newfoundland

The School Visits Program was initiated in 1980 by Newfoundland's provincial psychiatric hospital as part of the hospital's ongoing efforts to inform the community about mental health concerns and dismantle the wall of fear that prevents people from seeking support in times of emotional turmoil.

Each year, the hospital sends teams of mental health professionals to talk to junior and senior high school students. They show slides of Waterford Hospital, talk about mental health and mental illness, and attempt to dispel the myths and fears surrounding psychiatric illness and psychiatric treatment centers.

As a result of the program, communication between the hospital staff and teachers has improved. Students now contact the hospital for information in connection with school projects, and occasionally individuals with personal living problems find help as a result of contacts initiated by a school visit.

4.4 Peer Support - Adolescents Designing & ManagingTheir Own Health Networks

Barbara Davis, Red Deer, Alberta

Alberta's Peer Support Program is part of a larger, multi-dimensional prevention program for adolescents which has a history of involving youth in the design of projects related to their own concerns.

Peer Support uses the influence of the peer group to encourage the development of a positive self-image and responsible independence. At the same time, the program provides a structure within which adolescents can discuss personal and social issues related to their health needs and help design their own solutions.

Peer Support draws on the insights, skills and motivations adolescents already have. To these, it adds structure, training and adult support. This process results in programs that are both accessible and relevant to the needs of the youth involved.

Problem Specific Programmes

5.1 Effective Strategies for the Prevention of Motor Vehicle Related Trauma: The Case for Airbags

John Osterman, Pointe Claire, Quebec

During the past three years, a Quebec program has promoted the use of full frontal airbags in all vehicles as a means of reducing brain and cervical spine damage from highway accidents. This promotion has been a coordinated approach involving public health organizations; consumer and public interest groups; police and highway departments; and public officials and politicians from the transport and health fields at all three levels of government.

Because motor vehicle standards, including airbags, are a federal responsibility, the effort to make airbags mandatory should be Canada-wide. Next spring, the **Canada Gazette** will publish new "No Head Impact" criteria in an attempt to arouse public support for mandatory airbags.

5.2 AIDS Outreach Program

Linda Manzon, Vancouver, British Columbia

This nurse outreach program, sponsored by the B.C. Ministry of Health, was developed in January 1988 to bring counselling, testing and follow-up to street people considered high risk for contracting AIDS or STDs. A project manager and four street nurses work closely with other street organizations to assess the present and future needs of this population, which includes prostitutes, street kids, users of intravenous drugs and other substance abusers.

A street clinic provides privacy for counselling or a complete STD examination. This clinic distributes prevention kits which include street clinic business cards, condoms, bottles of bleach and water, and diagrammatic instructions for using them. Clients can have an HIV test on the street, or they can return to the clinic for a private consultation and a complete STD examination.

Street people and community workers like the program, and demands for its services have greatly increased since the introduction of a needle exchange program in January 1989.

5.3 Saskatchewan Institute on Prevention of Handicaps

Ann Schulman, Saskatoon, Saskatchewan

This nonprofit organization has a mandate to promote awareness of preventive measures for reducing the incidence of handicapping conditions in children. For the past nine years, the institute has concentrated on preventing handicaps that originate in the prenatal stage, but it is now beginning to work on preventing handicaps in the postnatal stage as well.

Institute staff are engaged in education, research and promotion. The institute has a network of contacts throughout the province through which staff can collect data, share information and promote strategies for prevention. The institute uses both electronic and print media to increase public awareness.

5.4 Active Life Program

Lise Ferland, Nicole Moir, Quebec City, Quebec

This is a Quebec program for seniors designed to maintain their functional autonomy through the use of physical exercise routines organized and conducted by seniors themselves.

The program has been extremely successful. After one year, 20,000 seniors have been reached, and 500 seniors groups are in place. One hundred volunteers and 50 counsellors have been trained and are actively involved.

Tuesday, March 14, 1989

Partners in Health

6.1 Dartmouth Health Promotion Study: Testing the comprehensive SchoolHealth Model

Anne Cogdon, Dartmouth, Nova Scotia

Community representatives and school staff in Dartmouth, N.S. have collaborated on a plan for a comprehensive health program for children in grades four through six. The program will focus on two topics: Heart Health and Mental Health.

The comprehensive model includes three components: health instruction, health services, and a healthy school environment. The Dartmouth program will also use community resources to complement and reinforce school activities.

This is a demonstration project funded by NHRDP, and the goal is to improve the information, attitudes and practices of school children about health issues. The study will begin in September, 1989, and follow-up evaluation will continue for four years.

6.2 The Role of the Medical School in Health Maintenance and the Prevention of Disease

Jock Murray, Halifax, Nova Scotia

Despite their acceptance by governments and the public, the principles of disease prevention, health promotion and health maintenance have not made much impact on the curricula of medical schools. Community Health and Epidemiology are still among the smallest departments.

To meet the challenges to the health care system, medical schools should be doing research in disease prevention, health promotion and health maintenance. The departments of Community Health and Epidemiology should be leading the research effort by assessing cost effectiveness, evaluating model

programs, assessing environmental factors and examining community patterns of disease.

Medical schools should be teaching students the principles of prevention and patient education. Students should learn about cost effectiveness, appropriate screening methods, management of risk factors and the use and misuse of diagnostic tests and hospitalization. They should be taught that the really important health issues are not "doctor business."

6.3 Employee & Family Assistance Program - A Successful Partnership

Jim Stimson, Vancouver, British Columbia

No report available.

6.4 A Handbook for Interpreters in Health

Rick Tremblay, Yellowknife, Northwest Territories

The handbook is intended to be a living/working document that allows interpreters to add dialect words to the book's diagrams and instructions. Once the changes have been made, the relevant pages can be photocopied and given to the patient.

The text is written in simple language, and scientific or medical terms are printed in bold type. This helps the interpreter identify words that need changing or adapting to the patient's dialect. Common nursing station problems are cross-referenced with discussions of relevant body systems.

The handbook will be used as a text for students seeking certification as medical interpreters at Arctic College for the Territories. The handbook is being distributed to all interpreters and nurses in the field and to related medical services in the north.

Research and Training Issues

7.1 Health Promotion Knowledge Development

Irving Rootman, Ottawa, Ontario

The Health Services and Health Promotion Branch of Health and Welfare Canada initiated this project in 1986. The goal is to develop knowledge that will assist health promotion in Canada.

Among other things, the project has so far resulted in an extensive review of extant research literature pertinent to health promotion, the drafting of a discussion paper on health promotion research priorities and strategies, and consultations with health researchers and others in over thirty workshops across Canada.

7.2 Health Promotion Training Handbooks for Community Health Workers

Catherine Martin, Montreal, Quebec

Five training handbooks have been produced for the use of community health workers in Quebec. Each book covers a different topic. These are:

- Health Promotion, Perspectives and Practice;
- Theories and Strategies;
- Health Promotion in Action - Developing Cooperative and Intersectoral Action;
- Educational Strategies for Improving Health in the Workplace; and
- Mental Health Promotion.

In addition, two training sessions have been planned. The first, on promoting health in the workplace, took place in the fall of 1988. The second, on health promotion, is scheduled for the fall of 1989.

7.3 Capital Regional District Health Database

Sylvia Roninson, Victoria, British Columbia

The Health Planning Database is composed of regional data about natality, mortality, morbidity and disability. The data is supplied by the Ministry of Health, the CRD Community Health Services and other agencies. CRD staff publish an annual health unit profile, but information is also available on request.

The Health Planning Database has affected community health service delivery in three ways. It has enabled managers to direct resources to areas of greatest need. It has challenged the assumptions of health care providers about health status and needs. It has uncovered new areas of concern.

7.4 Ontario Prevention Clearinghouse

Bryan Hayday, Toronto, Ontario

The Clearinghouse maintains a computerized database of health promotion programs, resources, research and regional contacts across Ontario. In addition to the information service, the Clearinghouse provides consultation, training, and educational activities for professionals and the general public.

The Clearinghouse supports local action through regional focus groups, toll-free access to information, consultation, research and participation in regional boards. Other activities involve negotiating intersectoral cooperation between health professionals and professionals in the field of community and social services.

Although the goals of the project always exceed the resources available, Clearinghouse services have been successful. They have helped increase local program activity in health promotion and primary prevention. They have also helped increase the amount of networking among the staff of programs in isolated areas.

Problem Specific Programmes

8.1 Assistance Program for Pregnant Women in Disadvantaged Areas

Marie-Paule Duquette, Montreal, Quebec

The Montreal Diet Dispensary (MDD) is a nonprofit agency which has developed a method of nutritional intervention (the "Higgins Method") to prevent low birth weights in babies born of mothers from disadvantaged areas. The Higgins Method consists of individualized nutritional follow-up and the taking of food supplements.

The rate of low-weight babies born of mothers treated at the MDD is half the usual rate for mothers from disadvantaged areas. The Quebec Department of Health and Social Services is testing the Higgins Method in one urban and one rural community service center before extending it to all pregnant women in disadvantaged areas throughout Quebec.

8.2 National Program to Reduce Tobacco Use

Cheryl Moyer, Toronto, Ontario

The National Program is a loosely structured collaborative framework for coordinating the anti-smoking activities of Canadian government agencies and health organizations. Every Canadian organization can become a "member" of the National Program.

The program has a Steering Committee which is responsible for planning and evaluation and for promoting the program throughout Canada. Members of the Steering Committee include the federal, provincial, and territorial governments and eight national health organizations. By promoting research and new program initiatives, the Committee hopes to achieve "a non-smoking that will assist in producing a generation of non-smokers by the year 2000".

8.3 Action on Drug Abuse

Irving Rootman, Ottawa, Ontario

This program was launched in May 1987 as a collaboration by six federal departments. It is being developed in partnership with the provinces and territories. The strategy, which balances the supply and demand aspects of drug abuse prevention, is an example of intersectoral coordination at both the international and national levels.

The presentation focussed on the part of the strategy for which the Health Promotion Directorate of Health and Welfare Canada is responsible.

8.4 Report from Quebec on AIDS and STDs

Marc Dionne, Quebec City, Quebec
Marie Droulin, Quebec City, Quebec

The Quebec plan of action to deal with AIDS went into effect on April 1, 1989. In March, the Ministry of Health and Social Services distributed a brochure to every household in the province.

The report described the way the brochure was received by the public and the media, how the plan would be implemented and what preventive measures would be used. The report stressed the relationship between AIDS prevention and preventing STDs.

Healthy Communities

9.1 Achieving Sobriety in Alkali Lake

Charlene Belleau, Williams Lake, British Columbia

During the past seventeen years, the Alkali Lake Band has moved from being 100 percent affected by alcoholism to 95 percent sobriety. This success is the result of several factors.

* Because Band leaders (the Chief and members of the Band Council) were role models for sobriety, they could require that someone had to be sober for two years in order to qualify for a job on the Band staff.
* The community accepted responsibility for its problems and relied primarily on its own resources instead of waiting for the federal government to fund an alcohol/drug program.
* Wherever possible, the Band provided support for individuals and couples to go for treatment. Once they were sober, band members participated in follow-up programs to stay sober.

In Alkali Lake, human development laid the foundation for economic development. Once people were sober, they wanted a job, a nice home and more education for themselves and their children.

9.2 Healthy Communities

Susan Berlin, Ottawa, Ontario

Using the World Health Organization's successful Healthy Cities Program as a model, Health and Welfare Canada has funded a three-year Canadian Healthy Communities Project to stimulate municipal interest in health promotion.

Participating municipalities agree to:

* Establish as *normative* an inter-departmental process for dealing with the health impact of policies and activities that come within their jurisdiction.
* Establish a body with representation from all municipal departments, the grassroots community and the private sector. This group's job is to assess the health needs of the community, set priorities for action and agree upon a small number of projects to address the community's needs.

9.3 The Four Worlds Development Project: Supporting Native Health Promotion from the Inside-Out

Michael Bopp, Pincher Creek, Alberta

This is a five-year research project to develop a generic model for health promotion programming in Native communities. The project has eleven components.

* Community mobilization,
* Development of a culturally appropriate framework,
* Needs assessment,
* Involvement of Health Services and Promotion Branch,
* A comprehensive health plan
* Community health leadership,
* Development of self-help groups and systems,
* Training of community personnel,
* Ensuring local control of health programs,
* Program implementation, and
* Long range technical support and training.

The project has been in operation for one year. It has been implemented in a manner consonant with Native spiritual values and traditional ways of healing, learning and sharing.

9.4 Kids' Place Project

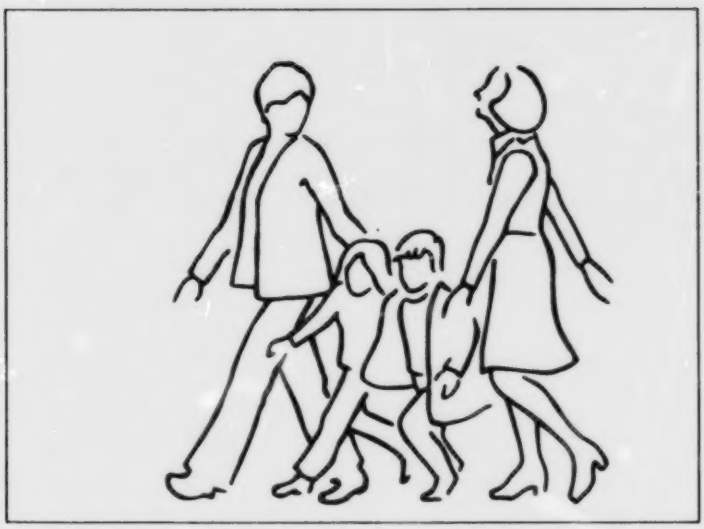
Jean Anderson, Edmonton, Alberta

The goal of the Kids Place Project is to improve the health of children and families in the deteriorating communities to the northeast of Edmonton's downtown core. These communities have a lot of transiency, unemployment and street violence. A large proportion of the children belong to single parent families on low incomes.

The Kids Place Project is directed by a steering committee of representatives from the community and local agencies, with help from an advisory group of children (the Kids Council). A needs survey of children in the area identified the following community health issues: safety, a safe meeting place for kids; traffic; community pride, and bylaw enforcement.

After a community meeting to discuss priorities, groups and organizations have initiated follow-up programs. These include a neighborhood watch program, upgraded street lighting and pedestrian crosswalks, and community-based police and fire department programs. In addition, the Kids Council has worked with community leaders to develop an after-school program.

OPPORTUNITIES



POLICY GROUPS

Policy Group Sessions

The policy group process was the central core of the symposium. Through this process, delegates to the symposium were asked to examine the future of health promotion activities in Canada into the next century. The following questions were posed for discussion.

* What areas offer the best opportunities for health promotion?
* What reasonable expectations exist for direct and indirect benefits from health promotion?
* Who should be involved in the delivery of health promotion activities?
* What are the costs and benefits of various health promotion activities?
* What sources of funding for health promotion activities are available?

By addressing the above issues, delegates were able to arrive at overall agreement on:-

I. **The challenges facing health promotion nation-wide.**
II. **The actions required to implement healthy public policy.**

The Process

Symposium delegates were divided into six policy groups, and each group was assigned a Facilitator and a Rapporteur. Groups met for two hours both afternoons in order to reach consensus on a variety of topics.

In the evening, the facilitators met to review the afternoon's activity. From the various policy group reports, the facilitators established an overall consensus and prepared a statement for the plenary session the next morning.

List of Facilitators and Rapporteurs

Chair: Sharon McDonald

FACILITATORS	RAPPORTEURS
Renaldo Battista	**Rene Rouleau**
Tariq Bhatti	**Nancy Cosway**
Peggy Edwards	**Suzanne de Maio**
Elaine Berthelet	**Jack Altman**
Robert Spasoff	**Lynne Blair**
Pat Wolczuk	**Marc Gallop**

Day 1: Challenges

On the first day, the policy groups discussed the challenges involved in "nation-wide planning for coordinated initiatives in health promotion and disease prevention to balance the attention now being directed toward the treatment of disease."

The lid was opened wide as delegates searched for answers to issues such as the following:-

* Policy costs/benefits
* Inequalities and inequities
* Changing patterns of disease
* Regulation and legislation
* Supportive environments

Each group was asked to agree on three challenges and to identify significant barriers to action on these challenges. The groups also identified opportunities for overcoming the barriers.

The policy groups then reached consensus on five major challenges:

I. Placing health promotion on public, professional and political agendas.
II. Achieving equity in the determinants of health.
III. Enabling community participation.
IV. Reallocating resources for health promotion.
V. Increasing intersectoral collaboration.

A complete statement of *challenges* can be found in the symposium policy consensus section of this publication.

Day 2: Actions

On the second day, the policy groups discussed the actions required to implement healthy public policy. Groups were asked to give special attention to the previous day's consensus on the challenges involved in health promotion.

This day provided intense discussion as the groups explored priority actions in areas such as:-

* The health impact of public policy
* Partnerships in non-traditional sectors
* Political and bureaucratic will
* Research agendas
* Information and education
* Training personnel
* Organizational structures

The policy groups arrived at consensus on three priority actions for each of the five challenges identified on the first day of the symposium.

A complete statement of these priority *actions* can be found in the symposium policy consensus section of this publication.

SUMMARY OF THE DEBATE ON POLICY CONSENSUS

Dr. Sharon Macdonald

Health, in its totality, encompasses more than the care of the sick and injured. As recognized by the World Health Organization, health is a resource for everyday living and health promotion is the process of enabling people in communities to increase control over, and improve, their health.

We should not forget that this conference is one of a series, initiated at the 1988, 29th Annual Premiers' Conference. Issues such as technology assessment and quality assurance, which are to be addressed in the next two conferences, are an important continuation to this symposium on Health Promotion and Disease Prevention.

Developments of systematic evaluation accountability structures within our current health care system will help to ensure that our health care initiatives reflect a recognition of our total health care goals.

This symposium has, as its goal, to stimulate the need for action across Canada. It is hoped that provincial delegates will sustain and build on the momentum created at this conference in their own jurisdictions. There is also the realization that much of our current health promotion efforts occur at the local community level, with women and families assuming major roles. In addition, Canada has also acknowledged its global responsibility in recognizing that health promotion extends beyond its national boundaries.

I hope that those opening thoughts set the context for what we are going to proceed to discuss in our challenges. What I would like to do is move through the challenges and then to come back to them individually, for discussion.

Clearly, there's more than one agenda here. Each of us identifies more clearly with one aspect of those three agendas; public, political, or professional. However, in order to reach our goals, we must get health promotion on to each of those agenda.

The agendas are interdependent. The politicians will listen to the public, they will listen to professionals. If the message that is coming from those groups to the politicians are not consistent with what you would like to hear as health promotion, then you're not going to succeed.

So we go back to the goal of the conference, and that is to act as a catalyst. If I talk as if each of you were a catalyst within your own region and we take that perspective, it's up to you then to figure out how you're going to get on to each and every one of those agendas. We will not attain a victory if we set out some sort of impossible political agenda for your Minister of Health, for your Minister of the Environment. This is not a helpful process.

There are a number of themes that were raised in the conference which really run across all the challenges and goals, and one of the things that I think pertains to that is identifying your leaders. You'll have to find your leaders in each of these areas and you will have to mobilize them.

What are the major mechanisms that you are going to use for doing that? Well, we use the word "communication" because, really, that's what it's all about. You've got to communicate your message.

Marketing techniques, brought up: we have to package it, we have to sell it. We have to help the public develop a new vision of what they want and what they need from health care and for health. It's a question of education. Within the public sector, we have to identify leaders: high profile, natural leaders. One of our speakers spoke quite eloquently to that.

Professionals have to be brought on line. You have to get them to buy into some or all of the process. You have to go out and meet them on their own grounds. The priority actions have to, somehow, be tied to current issues, and that's another theme that goes through all of our challenges. Identifying leaders runs

through all of the challenges, tying events to current issues runs throughout.

The other theme I think that runs throughout is we have to re-educate ourselves in order to accomplish those goals. Priority actions; consensus from the groups. Let's try and be clear about what our goals are. Let's somehow reach a consensus on that. Within each province, it's recommended that a unit of health promotion be established so that efforts can be focused, so that you have a driving force within government which moves things forward.

The last is marketing technique. Develop a simple consistent message. Not too may, a few at a time, simple and consistent. Those were reckoned by the groups to be the principal priority actions.

Intersectoral collaboration. There are many aspects to intersectoral collaboration; there are lots of sectors out there; there are lots that you want to mobilize.

The major mechanism that appeared to come out of the discussion groups was that we have to establish specific structures and processes, probably new ones - not in all provinces, some have them already. But we must establish and be prepared to take on new structures. Those structures will vary a little bit from province to province. We must also make an effort to tie those structures to the highest level of decision making that we possibly can achieve.

We're really touching here on healthy public policy and departments of health, you people, have to be prepared to act as the leaders and the catalysts. What are the priority actions? Establish intersectoral councils. Now, that means different things to different people. One of the major foci was on developing, within government, healthy public policy. Another focus was on bringing together different sectors which can sustain health promotion in its largest definition.

One of the more specific processes that came forward in one of the sessions was that it doesn't cost anything, except for people having to do a little thinking about it, primarily the bureaucrats. On all Treasury Board submissions, one is required to put in financial implications and communication strategies. So why don't we just add health impact analysis to that? It will evolve over time, we'll get more sophisticated was we go along, but it's one way of beginning to produce intersectoral collaboration.

We're talking about educating; we're talking about linking collaboration to topical issues. For instance, environment and polluting industries. And we're talking about collaboration having to occur at many, many levels. So you have to pick your targets; decide which area of intersectoral collaboration is appropriate for your province, and move ahead.

Reallocation of resources, it's such a nice phrase. As I moved around the policy groups, people were talking about it in the nicest of tones. Reallocation of resources is the dirtiest fight that there is.

I mean, let's be clear about it. This is not an easy process and it's not a nice process. People pull everything out of the bag. This is when you need people with the street smarts, the people you can send back into it to take another knock on the head. You've got to roll up your sleeves. This is where it's at. If you want to do things in our world, you have to garner some of the resources, whether they're human or fiscal, and you have to go after it. It's not a pretty arena. However, it's a very necessary one.

In keeping with the thought and the level of discussion there were some specific suggestions. In keeping with the nice words, the nice tone of reallocation of resources, we decided that we should take a very positive approach.

We mentioned that one of the barriers was that health promotion is forever being scrutinized. Tell us about yet another review of home care in this country. The reviews of the 3 percent of the budget. Let's start reviewing the other 94 percent. Rachlis says there's 23 percent waste; Kickbusch says maybe 25 in the current health care system, so let's go to where the bucks are. Let's start linking methods of funding to improvement of health status, current funding and future funding. It's not an easy task but we feel quite strongly that it's one that has to begin.

It also very much ties us in to the next two conferences. Technology assessment: how did we decide what money we're going to spend on which technologies.

Quality assurance: what do we need to do well; what are we doing well; what should we continue to do? Those really hit at the issues of funding.

This ties back to getting on to the agenda. The conversations about which dollars are going to go to where, when they come down to the last minute discussion, are not highfalutin' discussions. They get down to the brass tacks.

The efforts around marketing strategies have to come in here; communication has to come in here. You know, the bit of paper pulled out from the pocket to remind someone on the way to Treasury Board what they really thought they were going to do when they entered office two or three years ago. Remember? "Well, this is what you wanted to do; this is what you need to say when you go into that room." It's the last five minutes that count.

Other parts of the health care sector which have been funded over a number of years have all sorts of methods. Emergency rooms shut down, pain control clinics stop, radiation therapy equipment suddenly break down and can't be fixed. So we have to get smart. Surely to goodness we can learn something from those guys and really get in there and dig.

Having said that, we need to target dollar allocations for health promotion. There was some discussion that perhaps we need to tie this to a percent of the overall health care budget. We'd like to hear back from you, see what you think. It's kind of broad, a little fuzzy. I know you'll want to comment on it.

We need to improve evaluation techniques. We need to be able to evaluate better what we ourselves are doing, as well as what other people are doing and we really need to get some seed money out there and get some things on the road. Allow health promotion to show that it can, indeed, make some changes.

On to the next. Enabling community participation. This really gets at the crux of the issue as to who is going to spend the money, pay their tax dollars. What are we really talking about in that list of things that you have in front of you? Well, basically, we're talking about two things that have to happen if you're really serious about health promotion on the road.

What you're asking communities and individuals to do is to change. It's very difficult to change them from the outside, we know that. We have to work with them. A number of the speakers spoke very well to that. I think the Alkali Lake project in B.C. speaks to the fact. The only people who were really interested in changing Alkali Lake were the people who lived there and it took them a long time, 15 years, 20 years; the process is still ongoing.

So what are the major issues around enabling community participations? You have to come to grips with the facts that you have to decentralize decision making. You have to give away that power; you have to allow people to share it with you. You have to decentralize fiscal accountability. Bureaucrats are the only people in the world who think they can count money. You'd think that the rest of the world didn't shop.

Representation is the other aspect and that's a pretty broad mechanism, if you will. It almost isn't a mechanism. But somehow you have to allow the community to really be represented at many, many levels, in order to really undertake that community participation. What are some of the things you can do right now? Make some dollars available and demand innovation. Take some risks, do it. Empower communities to define their own needs. Let's listen to them. You've heard these things many times before. They've appeared in many documents. It's the consensus of the groups that we have to get down to business and do it.

The last challenge; equity. Equity really goes to the heart of the whole issue of health promotion. It appears in a number of documents. It needs to be addressed; it needs to be taken on as a challenge. What to do about it? Well, this is really going to vary from province to province and each province has to grapple with it, as Canada has to grapple with it as a country within the world.

Clearly, each of the provinces has to go home and establish a process and commit to a process to identify and redress inequities in the prerequisites to health. And we're talking about basic living conditions; sewer, water, housing, food. What are some of the priority actions? Let's ensure basic living skills and basic living

conditions. Let's empower people to develop those skills. Let's put the power back in their hands, get out of the cycle of powerlessness that one has, particularly, when you're involved in the income support programs. Let's reassess them; let's break that cycle of poverty.

The other priority action which can be undertaken is to focus on at least some programs and services, commit to delivering services as close to the people's community as possible, and to improve accessibility. Find some targets within each of your provinces; aim for them; do it.

It must be noted that participants called for both stronger and more toned down statements from the floor. Sharon Macdonald's summary captures the diversity of the debate. The final policy consensus statement reflects a final vote from the audience on the priority actions for the future.

NATIONAL SYMPOSIUM ON HEALTH PROMOTION AND DISEASE PREVENTION

POLICY CONSENSUS STATEMENT

Canada has one the finest systems of health care in the world. It is comprehensive, universal and more than adequately funded. In order to support this system, and to ensure that all Canadians enjoy the best possible health status, the participants of the first national symposium on health promotion and disease prevention believe that it is now time to acknowledge that health is more than health care.

Health, in its totality, encompasses more than the care of the sick and injured. As recognized by the World Health Organization, health is a resource for everyday living, and health promotion is the process of enabling people and communities to increase control over, and improve, their health. Symposium participants agreed that five major challenges for health promotion in Canada are:

I. **Placing health promotion on public, professional and political agendas.**

II. **Achieving equity in the determinants of health.**

III. **Enabling community participation.**

IV. **Reallocating resources for health promotion.**

V. **Increasing intersectoral collaboration.**

Getting on the agenda involves a greater emphasis on articulating health goals and communicating the health impact of societal decisions/policies in a way that will be understood by the majority of Canadians. Population groups with special needs and strategic problems for intervention should be targeted in order to ensure that the basic determinants for good health are available to all Canadians.

Communities must be empowered to define their own health needs and to set priorities in funding programs to meet those needs. Reallocation of resources within the health care sector should be accomplished through funding incentives that favor programs of proven effectiveness in achieving the desired health outcomes. Broad partnerships to promote health must be strengthened within the health system itself and across government departments, to include all relevant sectors of our society.

For each of these challenges, participants reviewed and affirmed the following mechanisms, priority actions, and action plans to successfully meet them in the months and years ahead.

Challenge I

PLACING HEALTH PROMOTION ON THE PUBLIC, PROFESSIONAL AND POLITICAL AGENDAS.

Mechanisms

Collaboration; research and evaluation; communication; marketing techniques.

Priority Actions

Establish broad health goals through an intersectoral process.

Develop a visible infrastructure to further health promotion, e.g. a health promotion office in each province.

Develop simple, consistent messages.

Supportive Actions

Include health impact analysis statements on all treasury board and cabinet submissions; establish health promotion models as "proof of concept" projects, e.g. in the workplace, public service; establish a health promotion database for public, professional and political use; facilitate professional collaboration in health promotion research and knowledge development; develop national health promotion campaigns on evolving issues, e.g. environment, poverty, literacy, etc.; develop a national communication campaign on health promotion utilizing social marketing techniques; encourage public support for politicians who work for healthier public policy.

Challenge II

ACHIEVING EQUITY IN THE DETERMINANTS OF HEALTH.

Mechanism

Establish a process to identify and redress inequities in the determinants of health.

Priority Actions

Ensure basic living skills and conditions.

Reassess income support programs.

Improve accessibility to programs and services.

Supportive Actions

Establish a commission on equity and basic living conditions; establish provincial health advisory committees on key issues and special need groups, e.g. natives and other cultural minorities, poverty, children, seniors, women, literacy; reassess welfare and unemployment systems, revising to eliminate the cycle of powerlessness; establish/enhance lifeskill education programs in schools; reassess provincial alcohol and tobacco taxes; consider establishing a guaranteed annual income policy.

Challenge III

ENABLING COMMUNITY PARTICIPATION.

Mechanisms

Information sharing; decentralization of decision-making and fiscal accountability; representation.

Priority Actions

Make dollars available to support innovation.

Empower communities to define their own needs.

Supportive Actions

Enable communities to gather their own health data and obtain community input, e.g. community forums; utilize the community development process to help communities determine their needs and make financial decisions; support communities in the development of their strategic plans for health; assign moneys (e.g. raised from alcohol and tobacco taxes) to communities or regions for health promotion initiatives; establish regional implementation committees; provide skill development programs for community members.

Challenge IV
REALLOCATION OF RESOURCES.

Mechanism

Link funding to methods of improving health status; target-setting.

Priority Actions

Target a specific dollar allotment for health promotion.

Improve evaluation techniques.

Identify seed money for health promotion initiatives.

Supportive Actions

Require greater accountability throughout entire health sector by rigorous evaluation with an emphasis on health outcomes; reorient public and professional support toward the need for a better balance between health promotion and health care; designate funds to clearly defined health promotion programs including "seed money" for pilot projects; define dollar requirements precisely for (re)allocation, e.g. a percentage of gross national product or percentage of the health dollar; support funding proposals within other ministries or departments which address inequities in health; require that new health dollars be restricted to initiatives that utilize health promotion principles and cost sharing among various levels of governments.

Challenge V
INCREASE INTERSECTORAL COLLABORATION.

Mechanism

Establish specific structures and processes.

Priority Actions

Establish intersectoral councils.

Strengthen intergovernmental cooperation.

Strengthen partnerships with key agents in the health sector and beyond.

Supportive Actions

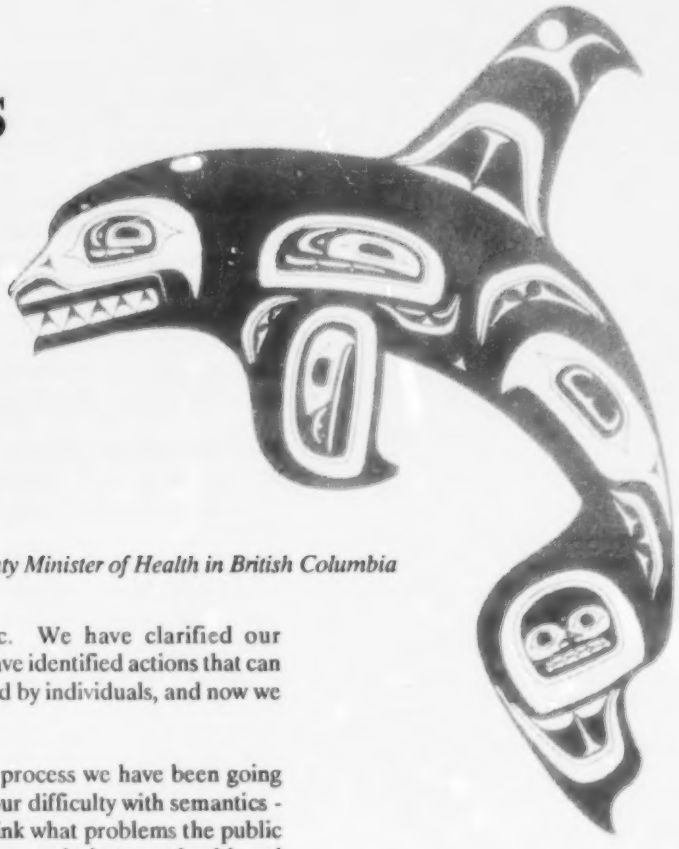
Establish intersectoral councils and committees (e.g. Ontario Premier's Council) with high-level accountability; establish and strengthen links to current public issues, e.g. environment; strengthen cooperation, both federal-provincial and provincial-community; build partnerships with health-care institutions and voluntary agencies; invite a variety of ministries, departments and agencies to conferences like this one; develop a national plan for healthy environments that considers Canada's global responsibilities.

Summary

Exploration of other issues, e.g. technology assessment and quality assurance, which are the subjects of the future symposia, must begin with the priority actions for health that have been agreed at this meeting. The development or improvement of systemic evaluation and accountability structures within our current health care system will help to ensure that future initiatives reflect our overall health goals and that resources are available to improve the health of Canadians.

This symposium was intended to act as a catalyst to foster nation-wide planning on coordinated initiatives in health promotion and disease prevention. It is hoped that delegates from across Canada will sustain and build on the momentum created at this event in their own jurisdictions. In doing so, it is recognized that, although we will be building on the foundation of current health promotion efforts, much of which occurs at the local community level, the priority actions identified in this report must become the first "order of business" at the community, provincial, and national level. Finally, in reaffirming health promotion as a national priority, Canada can take pride not only in improving the health of its citizens, but in acting on a responsibility shared with other nations to promote health around the globe.

SYMPOSIUM ACHIEVEMENTS



Stan Dubas, *Deputy Minister of Health in British Columbia*

Together, we have gone beyond rhetoric. We have clarified our understanding of health promotion, and we have identified actions that can be taken by governments, by communities, and by individuals, and now we must get on with the task.

Here are some personal observations of the process we have been going through. One of the things I picked up was our difficulty with semantics - definitions. And if we have problems, just think what problems the public has. For example, take that subtle distinction we make between health and health care. How many members of the public do you think make that distinction? They don't. Yet we believe everybody understands us.

Point number one is that there is an absolute need - a mandatory need - to be able to sensitize and educate the general public. And until you do, you're not going to have them on side. They won't understand what you're talking about.

Another factor is the lack of current research. Once again, we have an absolute need to measure public attitudes and then be able to measure changes in public behavior. This relates to some work in this province and in Alberta with attitudinal surveys, measuring the extent of public education with respect to health and health care.

In Alberta, they found that only 18 percent of the public were aware of, or educated in, the process of health care. When you're going to embark on a public relations campaign, you'd better know that, and you'd better know what the public currently does understand.

We've decided that we have to educate the public in order to change attitudes, because until you change attitudes, you can't go on to the second phase, which is changing behaviors.

Alberta decided to have a two-pronged public relations campaign, and in British Columbia we are going to do the same. We've decided that we have to educate the public in order to change attitudes, because until you change attitudes, you can't go on to the second phase, which is changing behaviors.

Alberta has been extremely successful in doing this, even within the period of 12 months. In that first 12-month period, they raised the level of understanding from 18 percent up to 28 percent. They're shooting for a target of 40 percent. Our target is to change the attitudes of 40 percent of the population before going on to that next phase.

The next point is not to lose sight of the wide gap between health care professionals and the general public, especially the disadvantaged public.

The majority of people here have had long-term experience in health care. We live it; we eat it; we're conditioned by it. But that's not true of the people we are relating to.

A year ago, I was transferred into the Ministry of Economic Development. Since I didn't know that I would be coming back within a year, I had a unique experience of being able to stand outside of the health care field for a while. I realized that most people thought of health care as, "When I'm sick, I want a place to go to where I can be looked after, be treated and get better."

In the minds of most people in the general public, health care isn't about the things we have been talking about. What I'm trying to say is that I hope we aren't developing a level of arrogance so that we will try to push our view of health care onto the general public.

This extends to the point of having to be sensitive about all of the players in both the health field and the health care field. We tend to go after turf, and we don't recognize some of the people that are already there. You can't exclude the environmentalists. They might not be health professionals, but they are there. You can't exclude those people that have been working with housing problems, the social workers, et cetera. They're there, and they're part of this team.

The field of health promotion is the jurisdiction of the team that includes both health care professionals and all those other specialties that together form a broad umbrella of assistance to health.

We have to be sensitive to all of the players. I'm especially sensitive to the medical profession, which has had a long and honorable role in preventive medicine, in counselling, in disease prevention, et cetera. They're partners in this thing, and I emphasize the word "partners". The field of health promotion is not the exclusive jurisdiction or prerogative of any one group of professionals. It is the jurisdiction of the team that includes both health care professionals and all those other specialties that together form a broad umbrella of assistance to health.

We have heard about the reallocation of resources, and we talked about the political will that is required to reallocate resources. I would submit to

you that part of this political will has to be at the bureaucratic level. My colleagues and I have to do some fighting over our various programs, and we've got to take some decisions as to how monies are going to be transferred between programs, because I believe that the entire system is adequately funded.

Study after study has said there is enough money in the system, but it's not going to the right areas. It can be more appropriately reallocated. We are working on it, and there is a commitment. There is certainly a commitment as we look at the implementation of new technology, et cetera, that as we get savings in the system, those savings can be moved about and reallocated. But that's not going to be done without a partnership of the people that are in the business, and I'm talking about hospitals; I'm talking about the medical profession and all those other health care workers that are currently funded out of the present system.

There has to be a consensus of opinion that this is the area that we believe will bring the greatest return on investment, in terms of health.

We heard about Dr. Michael Rachlis's book, *Second Opinion,* and the estimates of 25 to 30 percent inefficiencies and the savings that can be pulled out. Hell, let me reduce that down to five percent, and in this province five percent would be $200 million. You can go a long way with health promotion for a population of three million with $200 million. I'm being overly optimistic, but even one percent is a starting point. We couldn't use it all in one year or two years, but that's the kind of challenge in front of us.

In this province five percent would be $200 million. You can go a long way with health promotion for a population of three million with $200 million. I'm being overly optimistic, but even one percent is a starting point.

One of the things I would like to see accomplished out of this symposium is a consensus between the provinces and the federal government that within a year, we'll be able to make public our national and provincial strategy with respect to health promotion. We would be able to publish our goals and objectives, province by province, so that there would be a commitment, and we would be able to publish an action plan with measurable targets.

I think we can do it. I'd like to see every province have an annual business plan. We have one in this province now for the first time. The only way that we are finally going to get to our ultimate goal is by knowing what we're going to do, year by year. It's a management tool, but it's absolutely necessary unless you're willing to let the system go wherever it wants to. We've got to become more definitive than that.

Here is an example of something else I would like to see. Three years ago in this province, we had a serious problem with our services to the severely handicapped because of jurisdictional splits and because it was a neglected population. And one of the wisest things that we did was to produce a charter of our commitment to the severely handicapped. In that charter, we specified what we believed in, and we publicized it throughout the

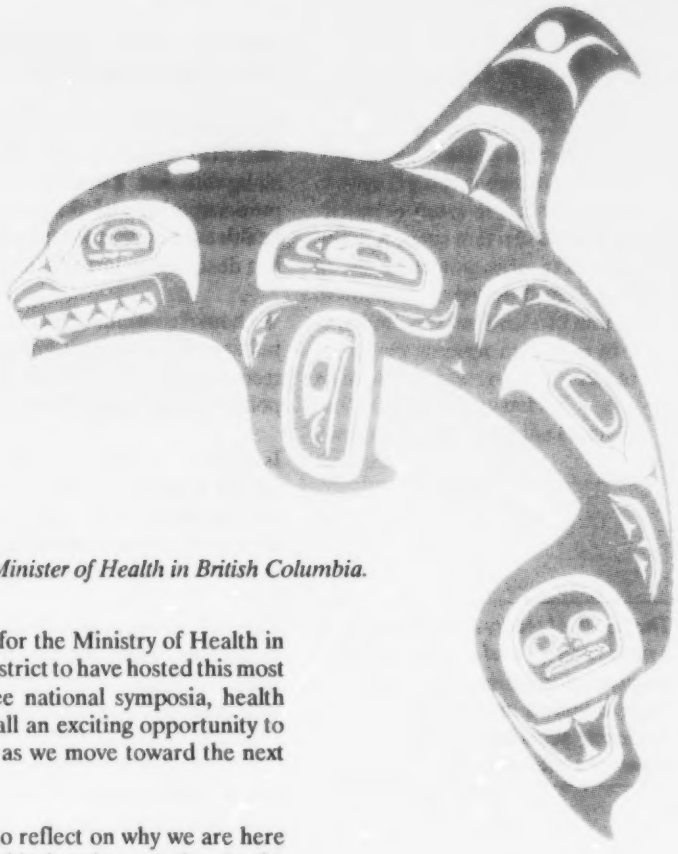
province so that every handicapped person would have a copy of it and know what they were entitle to.

Do you know, that went miles in terms of saying it and putting it in tangible terms. I believe that there should be a similar charter in terms of the health of the citizens of this country and, especially, the health of the citizens of this province.

I have one disappointment because everything else has gone well. It's a disappointment because it was an objective that we deputy ministers set up when we were originally talking about the three symposia. This being the first one, we wanted to focus public attention on health promotion, and in order to focus public attention on health promotion, you need the cooperation of the media.

It has been a disappointment that we have not been able to attract the appropriate media to this conference and be able to sensitize the public to the types of issues that were being discussed here and the types of directions that we're going in. However, it will serve as an extremely useful lesson for the future.

CLOSING REMARKS



Peter Dueck, *Minister of Health in British Columbia.*

First, let me say what a pleasure it has been for the Ministry of Health in British Columbia and the Capital Regional District to have hosted this most significant conference. As the first of three national symposia, health promotion and disease prevention offers us all an exciting opportunity to positively influence health policy in Canada as we move toward the next century.

As we close this symposium, it is important to reflect on why we are here and to look at how much closer we are in achieving those goals. As the Minister of Health, my colleagues across Canada and I were asked by our premiers to begin the process, to act as a catalyst for nationwide planning and coordination of initiatives.

These initiatives in health promotion and disease prevention need to be balanced against the attention now being directed toward the treatment of disease. This has been a sincere and important and bold challenge. The significance of this challenge is underscored by the fact that the news media are paying little attention to the issues that have been raised and the concerns that have been addressed. The bottom line is that, for the media at least, health promotion and disease prevention has no sex appeal.

Does the media's preoccupation with the curative side of sickness and disease - in short, the health care system we have today - accurately reflect public opinion? Or is it designed to just sell newspapers?

At this stage in the development of efforts to raise the profile of health promotion, we must realize that it simply does not have the same graphic sensational appeal as the type of headlines the public has been accustomed to: no debris of plane wreckage; no flashing lights or sirens; no life and death crisis being rescued by some high-tech intervention; none of the

emotional impact of seeing a struggling infant saved by a seemingly miraculous new procedure.

Let's face it; it's a pretty tough job trying to compete for space and air time with stories about hospital bed closures and the human suffering that goes along with that. The important question we need to ask is: does the media's preoccupation with the curative side of sickness and disease - in short, the health care system we have today - accurately reflect public opinion? Or is it designed to just sell newspapers?

Without a continuing focus on the issues we've discussed over the past, the public will not willingly embrace nor fully understand the need to reallocate resources to prevention in the pursuit of health. And here lies the critical political challenge. Who is it that wants to be first over the top?

Is it a brave soldier or is it a fool who, alone, is willing to test the opposition on the firing line? Make no mistake, this is a battle in its own right, this shifting of public attitude, belief and expectation. And like any battle, there is more than just security in numbers; there is a definite strength in having us move over the top in a unified fashion.

The political reality is that there is a need for a ground swell of public support before governments will begin to initiate meaningful economic shifts towards the preventive side of health.

This is the most urgent challenge facing not only ministers of health, but all politicians. The political reality is that there is a need for a ground swell of public support before governments will begin to initiate meaningful economic shifts towards the preventive side of health.

These discussions have greatly expanded my vision of the essential role which health promotion and prevention of disease will play in the future of health care in this country. We were asked to focus on the challenges facing us with respect to health promotion, and we were asked to look at the actions needed to implement health promotion policies and programs throughout Canada. I believe you have done that.

You have identified a significant challenge for ministers of health and provincial premiers and government leaders across this country. While it is comforting to know that all of you are willing to take up this important cause, I want you to know that I fully understand the enormity of the challenge you have presented to us in the political arena. The challenge is radical. It is not a challenge for weak leaders.

We know we have a health care system in Canada that is the envy of the world, and we must never forget that, for Canadians, it is a sacred trust. As governments, we are mandated to protect and preserve that trust. What we are suggesting here is change, significant and bold change.

While public attitude may be changing too, it has not yet arrived at our level of understanding of the issues. I'm afraid that any attempt to change the status quo will be viewed by many as a threatening move, a move that will be seen as taking something away as opposed to making the system better.

It will take both our political will and some very strategic initiatives to raise public awareness in order to build the necessary public consensus to support the change we need.

This is the first of three symposia designed to improve efficiencies in health and provide a road map for the future, and we cannot conclude this initiative until the circle has been completed. This conference is but one component, albeit a critical one - perhaps in some way the most critical, for it is the beginning.

I'm afraid that any attempt to change the status quo will be viewed by many as a threatening move, a move that will be seen as taking something away as opposed to making the system better. It will take both our political will and some very strategic initiatives to raise public awareness in order to build the necessary public consensus to support the change we need.

For my part, I will be following through with a renewed commitment by refocusing initiatives within my Ministry and by pursuing a higher priority for health promotion in British Columbia. I will begin that by establishing an Office of Health Promotion which will pursue consultations with British Columbians throughout our province.

This conference has provided the momentum to ensure that we will remain committed to following through with these initiatives. It has given me the incentive to have British Columbia join the growing number of other provinces with offices of health promotion by establishing our own office with a mandate to keep this process alive.

It has been a long three days. I know that most of you, while feeling tired from the process, are at the same time renewed by the experience and rejuvenated by the fact that we have come this far together. The challenge now is for us all to apply that feeling of energy and renewal to produce concrete action. We have a formidable challenge before us, but we all know that the benefits will be worth an aggressive, sustained pursuit of a healthier Canada.

At the risk of sounding like I'm a book salesman, I would like to close by referring to the book *Second Opinion* written by Dr. Michael Rachlis and Carol Kushner.

The book describes a person standing on a river bank who, hearing cries for help, jumps into the river, rescues the victim and begins applying artificial resuscitation. Moments later, he hears another cry for help, and once again, he jumps in and does the same thing. Soon there is a third, a fourth and a fifth, and eventually, it becomes an endless rescue exercise. As he begins to tire from his labors of rescuing these people in need, he realizes that if he only had the time, what he really should be doing is going up the river to find out who is pushing all these people into the river.

You know, our current state of health is much like that, and I see the challenge as two-fold: first, to recognize that something is happening upstream that we must become aware of; and second, to find ways to change what's happening upstream and to begin to reduce the number of rescues. It comes down to either stopping people from being pushed in or teaching them how to swim.

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WHAT THEY SAID...

"Now we are getting down to brass tacks. This conference is saying what really ought to be done in Health Promotion."

"We have got to establish a strong body of public support to allow the politicians to go ahead and do the things which they understand they need to do."

"If we really got into evaluation, vigorous evaluation of the outcomes of what we are doing, both in the acute and in the preventive sector, we would have lots of money which could then be diverted into health promotion and disease prevention."

"We need ways and means to help people get inside and feel their own self and their spirituality as part of their health."

"I do not see any utility in trying to shift resources and change our priorities unless we do it jointly...The industry is large; the issues are large; the interests are large."